United States Court of Appeals

for the Second Circuit

APPELLANT'S BRIEF

75-6128

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P/S

United States Court of Appeals

FOR THE SECOND CIRCUIT

GREATER NEW YORK HOSPITAL ASSOCIATION and PENINSULA HOSPITAL CENTER, on behalf of themselves and all other voluntary nonprofit hospitals which are members of GREATER NEW YORK HOSPITAL ASSOCIATION and which are reimbursed for Medicare services rendered to hospital patients under the Periodic Interim Payments Plan established in 1963,

Plaintiffs-Appellants,

UNITED HOSPITAL, PUTNAM COMMUNITY HOSPITAL, PHELPS MEMORIAL HOSPITAL ASSOCIATION, COMMUNITY GENERAL HOSPITAL OF SULLIVAN COUNTY, THE CORNWALL HOSPITAL, NORTHERN DUTCHESS HOSPITAL, NYACK HOSPITAL, ST. AGNES HOSPITAL, WHITE PLAINS HOSPITAL, MERCY HOSPITAL, ST. CHARLES HOSPITAL, NASSAU HOSPITAL, SOUTH NASSAU COMMUNITIES HOSPITAL, NORTH SHORE HOSPITAL, BROOKHAVEN MEMORIAL HOSPITAL, LONG BEACH MEMORIAL HOSPITAL, SOUTHSIDE HOSPITAL, GOOD SAMARITAN HOSPITAL, HUNTINGTON HOSPITAL, SOUTHAMPTON HOSPITAL, COMMUNITY HOSPITAL AT GLEN COVE, ST. FRANCIS HOSPITAL, EASTERN LONG ISLAND HOSPITAL, ST. JOSEPH'S HOSPITAL OF YONKERS and CENTRAL SUFFOLK HOSPITAL ASSOCIATION,

Intervenor Plaintiffs-Appellants,

—against—

DAVID MATTHEWS as Secretary of the UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE, and JAMES B. CARDWELL, as United States Commissioner of Social Security,

Defendants-Respondents.

BRIEF OF PLAINTIFFS-APPELLANTS

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BRIEF OF PLAINTIFFS-APPELLANTS

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

1. Whether judicial review of the promulgation by the Secretary of Health, Education and Welfare under his rule-making authority, 42 U.S.C.§1302, of a regulation changing a method of reimbursing voluntary hospitals for services rendered to Medicare patients is barred by the Administrative Procedure Act (5 U.S.C. §701).

2. Whether the regulation referred to above violates the Medicare Act (42 U.S.C. §1395 *et seq.*) and Regulations (20 C.F.R. §§405.401, 405.402, 405.403, 405.405, 405.451, 405.452, 405.453, 405.454).

3. Whether the promulgation of the regulation referred to above by the Secretary of Health, Education and Welfare was arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law.

4. Whether the application of the regulation referred to above will cause irreparable injury to the members of the Class represented by the appellants.

STATUTES AND REGULATIONS INVOLVED

These are set forth in an Addendum to the Brief, ("Addendum",) *infra*, p. 48.

STATEMENT OF THE CASE

This is an appeal from an order of Judge Charles M. Metzner of the United States District Court for the Southern District of New York, issued on December 11, 1975, dismissing the complaint. The District Court's order is not reported.

At issue in this case is the reviewability of the promulgation by the Secretary (hereinafter the "Secretary") of the United States Department of Health, Education and Welfare (hereinafter "HEW") of a regulation which radically changes the method by which the members of the class are reimbursed for services rendered to Medicare patients.

The Class in this action is composed of members of the Greater New York Hospital Association who are presently being reimbursed under the old Periodic Interim Payments Medicare reimbursement method (hereinafter "Old PIP"). Under the Old PIP method, hospitals are paid weekly by HEW and there is an average three day lag between the time a hospital delivers services to patients and its receipt of reimbursement therefor. Under the new PIP regulation, 20 C.F.R. §405.454(j) (hereinafter "New PIP"), hospitals would be paid bi-weekly and the payments would be made at least two weeks after the services are rendered. This would result in an average three week lag between the

rendition of hospital services and the payment therefor (Part A Intermediary Letter No. 75-58; Appendix 282a-285a). The Secretary and the Commissioner of Social Security (hereinafter the "Commissioner") planned to convert hospitals on the Old PIP system to the New PIP system by a gradual withholding of moneys due the hospitals during the period from December 1, 1975 to May 31, 1976. By the latter date, the hospitals would have been deprived of an amount equal to three weeks of Medicare payments.

The uncontradicted testimony plainly establishes that this change in the regulation after eight years of operation under the old system will result in extraordinary harm to the hospitals, permanently depriving them of about $35,000,000 of cash flow without any commensurate benefit to the government.

On November 21, 1975, appellants commenced this action for preliminary and permanent injunctive relief and a declaratory judgment. On the same day, Judge Metzner issued a temporary restraining order enjoining the Secretary and Commissioner from converting hospitals from the Old to the New PIP system.

On November 28, 1975, a hearing was held on appellants' application for a preliminary injunction. At the conclusion of this hearing, Judge Metzner extended the temporary restraining order until December 11, 1975.

On December 1, 1975, the Secretary and the Commissioner withheld Medicare payments for the preceding week from hospitals on Old PIP which were not represented in this action. On December 3, 1975, twenty-five of these hospitals made a motion to intervene. Judge Metzner granted the motion and stated that the determination of the motion for the preliminary injunction would be binding on the intervenors without any further evidence being adduced.

Subsequent to November 28, all parties agreed that the hearing on the preliminary injunction should be treated as the trial of the action on the merits.

On December 11, 1975, Judge Metzner issued a final decision in this action denying appellants' application for a permanent injunction and declaratory judgment on the ground that respondents' promulgation of New PIP as a replacement for Old PIP was committed to agency discretion and therefore unreviewable under the Administrative Procedure Act (hereinafter the "APA").

On December 12, 1975, appellants filed their notice of appeal from the order and judgment of Judge Metzner and he ordered that respondents be stayed from applying or attempting to apply New PIP to the appellants or appellants-intervenors until December 23, 1975, when appellants' motions for a stay pending appeal would be heard by this Court.

On December 12, 1975, appellants filed with this Court a motion for a stay pending appeal. This motion was subsequently withdrawn upon respondents' representation that they would refrain from converting the hospitals which are parties to this suit to the New PIP system until the final determination of this appeal. By letter dated December 17, 1975, Frederick P. Schaffer, the Assistant United States Attorney in charge of this case, advised counsel for appellants that the stay of the conversion would remain in effect until this Court renders an opinion.

On December 29, 1975, appellants-intervenors filed their notice of appeal.

FACTS

In 1965 Congress enacted the Medicare Act, 42 U.S.C. §1395 *et seq.* which established a health insurance program for persons age 65 and older. Under the provisions of this law, hospitals are reimbursed for the reasonable cost of services rendered to individuals covered under the program. 42 U.S.C. §§1395f(b), 1395x(v)(1)(A). The amount of Medicare reimbursement received by a hospital each year is not calculated on the basis of individual bills to Medicare patients. Rather, total allowable hospital costs are aggregated on an annual basis and then, by a

sophisticated accounting system, the percentage of these costs which can be attributed to services rendered to Medicare beneficiaries is determined. 42 U.S.C. §1395x(v)(1)(A), 20 C.F.R. §§405.402, 405.403, 405.405, 405.451, 405.452, 405.453. Although the final calculation and adjustment of payments for Medicare costs is made at the end of the fiscal year, payments based on estimated costs are made to the hospital on an interim basis throughout the year in order to insure that providers will have adequate resources for the further rendering of services. 42 U.S.C. 1395g; 20 C.F.R. §§405.402, 405.405, 405.454.[1]

Establishment of Old PIP Method

The original reimbursement system established by HEW under the Medicare program conditioned hospital interim payments on the receipt of individual patient bills. Because this was a vast new program with which neither the hospitals nor the fiscal intermediaries nor the Social Security Department had any experience, an enormous backlog of bills developed and hospitals, particularly those in the New York City area, developed acute cash flow problems (Appendix pages 57a, 60a).[2] Services were being rendered by

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1. Actual payments to hospitals are made by fiscal intermediaries which act as agents for the government. In the metropolitan area, the fiscal intermediary for most hospitals is Blue Cross and Blue Shield of Greater New York.

2. Hereinafter, references to pages in the Appendix shall be (a).

the hospitals but payments were not being received from the government on time. In order to remedy this situation, on January 1, 1968 HEW offered the hospitals an alternate system of payment under which interim payments are independent of the processing of the final invoices (58a, 60a). Hospitals electing reimbursement under this method of "Periodic Interim Payments" ("Old PIP") receive from their fiscal intermediary (54a, 55a), 1/52 of their estimated annual cost of Medicare services each week, regardless of the number of bills they submit (59a). The hospitals, however, are still required to submit their bills promptly and such bills are, of course, subject to final audit and adjustment. Payment under "Old PIP" results in an average three day lag between the time a hospital delivers services and receipt of reimbursement therefor (Part A Intermediary Letter No. 75-58; (282a-285a)). Sometime after the end of the fiscal year, the fiscal intermediary audits the hospital's records and about two years later makes an adjustment which will either result in an additional payment to the hospital or a refund to the Government (59a, 101a). Over 95% of the Medicare payments in New York City are made under the Old PIP system (274a). In more than 90% of the cases the audit results in additional payments being made to the hospitals (189a).

On January 29, 1973, the Secretary, without giving any explanation, announced a freeze of Old PIP, under which no additional hospitals would be permitted to elect payment under the Old PIP system until July 1, 1973. This change in policy did not affect hospitals already being paid under this system.

Announcement of New PIP Method

In June 1973, hospitals were informed by HEW that pending a review, the freeze on Old PIP had been extended until further notice (Part A Intermediary Letter No. 73-24 (297a-300a)). Again, no reason or explanation was given for this decision. On September 1, 1973, Part A Intermediary Letter No. 73-37 (293a-296a) was issued for use pending publication of new regulations. It created a new PIP method ("New PIP") for hospitals and other providers electing coverage after August 1973, and continued the freeze on Old PIP without explanation. Under the New PIP method, payments are made for a two week service period and are issued no earlier than two weeks after the end of the service period to which they apply. This new bi-weekly system results in an average lag of three weeks between the delivery of service by the hospital and the disbursement of payment for such service.

On July 16, 1975, the final regulation establishing New PIP and specifically requiring hospitals to convert from Old PIP to New PIP by September 15, 1975 was published (40 Fed. Reg. 29815-17 (1975)) (288a-289a). As in the case of the publication

of the earlier intermediary letters and proposed regulation, no reason was given for adopting New PIP as a replacement for Old PIP. The Secretary did acknowledge, however, that he had received a great many objections to the New PIP regulation; these objections asserted that the New PIP payment schedule

> would severely hinder the cash flow of providers and their ability to meet working capital needs since a major share of providers' costs are associated with personnel payrolls and payments to vendors that are typically paid on at least a weekly or bi-weekly basis,... 40 Fed. Reg. 29816 (1975); (289a).

On September 2, 1975, the Secretary extended the date for complete implementation of New PIP to May 31, 1976 on the ground that the original September 15th date would

> create extraordinary cash flow problems for these hospitals, especially those located in the large urban centers, making it necessary for the hospitals to borrow equivalent funds from conventional lending sources. 40 Fed. Reg. 40192 (1975); (286a).

The Secretary, however, did not explain the basis for his apparent conclusion that the hospitals' cash flow problem would be solved by the extended implementation date.

In October, 1975, Part A Intermediary Letter No. 75-58 (282a-285a), containing the procedure whereby hospitals on Old PIP were to change over to New PIP, was issued. Under the terms of

the letter, a hospital's December 1 Medicare payment would be withheld, the hospital would be placed on a bi-weekly schedule beginning on December 8, and, commencing December 22, an amount would be deducted from the hospital's subsequent bi-weekly payments. By May 31, 1976, there would be an average three week lag between the rendering of Medicare services by the hospital and the receipt of payment. This fact is confirmed by HEW in Part A Intermediary Letter No. 75-58, dated October, 1975, at page 2:

> When these requirements are fully implemented, PIP payments to all providers will contain an average lag of three weeks between delivery of service and disbursements of payment for the services, as required by the regulations. (283a)

Ruinous Effect of New PIP on the Hospitals

The effect of the conversion from Old PIP to New PIP will be disastrous to the members of the Class. Not only will it result in an aggregate loss of approximately thirty-five million dollars in cash flow by May 31, 1976 (64a, 66a), but it will also make it extremely difficult, and in some cases impossible, for the hospitals to meet their current financial obligations. Most of the members of the Class will have to try to borrow to make up for the lost cash flow thereby incurring large additional interest expenses which will be only partially reimbursed by Medicare. Because they already have large loans outstanding and lack additional collateral, some hospitals will be unable to borrow more money (95a, 101a). These hospitals

will have to try to compensate for lost cash flow by delaying payment of bills to their vendors. Since the vendors in effect become bankers, they charge for the use of their money by imposing higher prices for their goods (100a-101a, 170a). This, of course, also increases hospital costs. In many cases, the lack of funds will cause hospitals to curtail vital health services (147a, 149a, 150a, 170a, 180a, 181a).

In sum, the New PIP program will serve only to fuel the fires of inflation by increasing hospital costs and, in some cases, will force the elimination of hospital services in the City. As we show below, none of this results in any commensurate benefit to the Government.

SUMMARY OF ARGUMENT

1. The determination of the Secretary of HEW in issuing the regulation establishing the new PIP payment system is subject to judicial review. The Supreme Court has held that any exception to judicial review should be narrowly applied. See Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402 (1971); Barlow v. U.S., 397 U.S. 159 (1970). In Overton, the Court specifically held that judicial review of an administrative action is only to be denied when there is a "clear and convincing showing of a legislative intent to prohibit judicial review." There is no such showing here. The District Court's dismissal of the complaint on the ground that the fixing of Medicare payment dates is directed to agency discretion by statute and there is no "law to apply" is erroneous. (Point I)

2. The new regulation violates the overall intent of the statute as well as relevant provisions of the Medicare Act and regulations which require that hospitals be reimbursed the reasonable cost of services and prohibit the shifting of costs of Medicare beneficiaries to non-Medicare beneficiaries. (Point II)

3. The new regulation is arbitrary, capricious and represents an abuse of discretion by the Secretary. The administrative record does not support the reasons enunciated by the Secretary for the promulgation of the new regulation. (Point III)

4. The new regulation will deprive members of the Class of approximately $35,000,000 in working capital funds. This will cause

irreparable injury. The uncontradicted evidence demonstrates that the hospitals will either have to borrow money to make up the loss, thus incurring unnecessary interest costs, or, if they are unable to borrow, they will be forced to eliminate essential hospital services. (Point IV)

ARGUMENT

POINT I

THE PROMULGATION OF THE REGULATION REPEALING THE OLD PIP MEDICARE REIMBURSEMENT SYSTEM IS SUBJECT TO JUDICIAL REVIEW

The District Court determined that 42 U.S.C. §1395g of the Medicare Act which provides that

> The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly)....

placed the promulgation of the New PIP regulation within the APA's exception to judicial review for agency action "committed to agency discretion by law", 5 U.S.C. §701(a)(2). This is a clear misapplication of the exception.

The Supreme Court has consistently held that any exception to judicial review should be narrowly applied. Citizens to Preserve Overton Park v. Volpe, 401 U.S. 402, 410 (1971); Barlow v. Collins, 397 U.S. 159, 166-67 (1970).

In Barlow, the Court considered the rulemaking power of the Secretary of Agriculture pursuant to 16 U.S.C. §590d(3). This section authorized the Secretary to "prescribe such regulations, as he may deem proper to carry out the provisions of . . . [the Food and Agriculture Act of 1965]." Id. at 165. In holding that this language did not preclude the right of tenant farmers to challenge a regulation which they alleged would place them at the economic mercy of their landlords, the Court stated:

> [T]he authority to promulgate such regulations "as he may deem proper" in §590d(3) [does not] constitute a commitment of the task of defining "making a crop" entirely to the discretionary judgment of the Executive Branch without the intervention of the courts.
>
> * * * *
>
> The question then becomes whether non-reviewability can fairly be inferred. As we said in Data Processing Service, preclusion of judicial review of administrative action

> adjudicating private rights is not lightly to be inferred [citations omitted]. Indeed, judicial review of such administrative action is the rule, and nonreviewability an exception which must be demonstrated. In Abbott Laboratories v. Gardner, 387 U.S. 136, 140, we held that "judicial review of a final agency action by an aggrieved person will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress." 397 U.S. at 165-167.

The holding in Barlow, supra, should be controlling in the instant case because the statutory language which granted rulemaking authority to the Secretary of Agriculture is almost identical to that governing the authority of the Secretary of HEW to provide for Medicare payments, 42 U.S.C. §1395g, the latter being "as the Secretary believes appropriate (but not less often than monthly)". In addition, the petitioners in Barlow, like those in the present case, were seeking review of an agency determination with broad public ramifications.

In Barlow, supra, the protection of a large economically underprivileged group was at issue. At stake in the present case is the continuing financial viability of the New York City voluntary hospitals, and thus their attendant ability to continue providing necessary health services to the public.

Judge Metzner based his dismissal of the complaint on Overton, supra. That case dealt with both exceptions to judicial

review contained in the APA: the "discretion" exception and the exception for "statutes [which] preclude judicial review" 5 U.S.C. §701(a)(1)(2).The District Court correctly read Overton as requiring that there be a "clear and convincing showing of a legislative intent to prohibit judicial review" in order for the "statutory" exception to apply (318a). However, it incorrectly interpreted this case as requiring a different standard of proof for the "discretion" exception when the statute under which review is sought is silent on the question of judicial review. Although the Court in Overton used different language to characterize the "discretion" exception, (namely that it is applicable in those rare instances where 'statutes are drawn in such broad terms that in a given case there is no law to apply'"(401 U.S. at 410)),it is clear from another Supreme Court case, Association of Data Processing Service Organizations, Inc. v. Camp, 397 U.S. 150 (1970) that the same restrictive view should apply to both exceptions.[3]

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3. The Court in Overton in no way attempted to distinguish or overrule its decision in Data Processing Services.

Moreover, in its analysis of the discretion exception, the Court relies on Berger, Administrative Arbitrariness and Judicial Review, 65 Col. L. Rev. 55 (1965) which takes the position that:

> It would be strong medicine to read a remedial statute so as to cut off review of decisions unsupported by evidence, or of

(footnote cont.)

Data Processing Service involved a challenge to a regulation of the Comptroller of the Currency permitting national banks to offer data processing services. In rejecting the Comptroller's claim that judicial review of the regulation was barred by the APA, the Court did not distinguish between the "discretion" and "statutory" exceptions but, rather, applied the same criteria to both.

> In Shaughnessy v. Pedreiro, 349 U.S. 48, 51 we referred to "the generous review provisions" of that Act [The Administrative Procedure Act]; and in that case as well as in others (see Rusk v. Cort, 369 U.S. 367, 379-380) we have construed that Act not grudgingly but as serving a broadly remedial purpose.
>
> We read §701(a) as sympathetic to the issue presented in this case. As stated in the House Report:
>
> > "The statutes of Congress are not merely advisory when they relate to administrative agencies, any more than in other cases. To preclude judicial review under this bill a statute, if not specific in withholding such review, must upon its face give clear and convincing evidence of an intent to withhold it. The mere failure to

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(cont. footnote 3)

> action in excess of statutory jurisdiction or without observance of legal procedure. Minimally we should ask for the clearest evidence, even in the teeth of the most unambiguous words, before attributing to Congress an intention by a remedial statute to accomplish such remarkable results. Id. at 58-59.

provide specially by s[illegible]tute for judicial review is cert[illegible]nly no evidence of intent to withhold review." H.R. Rep. No. 1980, 79th Cong., 2d Sess., 41.

There is no presumption against judicial review and in favor of administrative absolutism (see Abbott Laboratories v. Gardner, 387 U.S. 136, 140), unless that purpose is fairly discernible in the statutory scheme. Cf. Switchmen's Union v. National Mediation Board, 320 U.S. 297.

397 U.S. at 156-57.

On the basis of Data Processing Service as well as Barlow, it is clear that judicial review is appropriate here since Judge Metzner specifically found that

> [i]n the instant case, there is no clear and convincing showing of a legislative intent to prohibit judicial review. (318a).[4]

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4. Where, as in the instant cases, there is no express grant of review, reviewability has ordinarily been inferred from evidence that Congress intended the plaintiff's class to be a beneficiary of the statute under which the plaintiff raises his claim. [citations omitted] In light of Abbott Laboratories, slight indicia that the plaintiff's class is a beneficiary will suffice to support the inference.[9]

> 9. This is particularly the case when the plaintiff is the only party likely to challenge the action. Refusal to allow him review would, in effect, commit the action wholly to agency discretion, thus risking frustration of the statutory objectives.

Barlow, supra, at 174-75 (Brennan, J., concurring in the result and dissenting).

But, even if the District Court's interpretation is accepted, its holding is still incorrect. There is "law to apply" in this case.

The District Court concluded that there was "no law to apply" for two reasons. First, it determined that there was no legislative interest in the question of Medicare payment beyond the concern that it be at least monthly (319a). Second, it found that 20 C.F.R. §405.454(b) which provides that "intermediaries are expected to make payments on the most expeditious basis administratively feasible" did not apply to the New PIP regulation (319a-320a).

In its analysis of legislative intent, however, the court limited its examination to one section of the Medicare Act rather than viewing the overall purpose of the statute. The Congressional proceedings preceding the adoption of the APA make it clear that agency action must conform to the intent of a statute and that the statutory purpose can, in fact, provide "law to apply".

> Mr. Springer [Representative from Indiana]
>
> The second provision, to which I now refer, provides "and hold unlawful and set aside agency action, findings, and conclusions found to be arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."
>
> To my mind, that is a most potent statement and is a fair and equitable provision of the bill.

MR. SCRIVNER [Representative from Kansas] Mr. Chairman, will the gentleman yield?

MR. SPRINGER. I am happy to yield to my friend from Kansas.

MR. SCRIVNER. Does the gentleman feel that that would correct the evils that might exist where a regulation was contrary to the intent, spirit, or purpose of the act?

MR. SPRINGER. I think unquestionably, it would. The gentleman is precisely correct. That is the purpose and that is the intention of that provision which has been written into this bill....

> Administrative Procedure Act Leg. History, H.R. Doc. No. 248, 79th Cong., 2d Sess. 377 (1946) (emphasis added).

In Overton, supra, it was, in fact, legislative intent, namely the protection of public parkland, which constituted the "law to apply" 401 U.S. at 412, n. 29.[5]

The purpose of the Medicare program was to "provide basic health insurance protection for people age 65 and over",

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5. Overton involved a challenge to the authorization of federal funds for the construction of an interstate highway through a public park by the Secretary of Transportation. The Court found that the legislative intent was expressed in the Department of Transportation Act of 1966 and the Federal-Aid Highway Act of 1968 which prohibits the Secretary from authorizing federal funds for highway construction through public parks if a "'feasible and prudent' alternate route exists" or if there has been "'all possible planning to minimize harm' to the park". 401 U.S. at 405.

Report of Senate Committee on Finance, S. Rep. No. 1431, 91st Cong., 2d Sess. 93 (1970), and to "encourage participating institutions, agencies, and individuals to make the best of modern medicine more readily available to the aged." U.S. Code Congressional and Administrative News, 89th Cong., 1st Sess., 1965 (1965). In line with this, the Secretary is only permitted to promulgate regulations under his rule making authority "necessary to the efficient administration" of his functions under the Medicare program. 42 U.S.C. §1302 (emphasis added). As the record shows, the implementation of the New PIP system will result in either the curtailment of vital health services or an increase in health care costs (147a, 150a, 170a, 180a, 181a). Those affected will be not only the elderly population but also the indigent and working poor of the City of New York. This is clearly the kind of inefficient administration which contravenes the intent of the entire Medicare Program.

The District Court's concentration on 20 C.F.R. §405.454(b) as a reason for denying judicial review completely overlooks the fact that appellants have argued all along that the statute and regulations which supply "the law" in this case are those which proscribe (1) the shifting of the costs of Medicare beneficiaries to non-Medicare beneficiaries, 42 U.S.C. §1395x(v)(1)(A), 20 C.F.R. §§405.402, 405.403, 405.405, 405.451(b), and (2) the failure of the

Secretary to reimburse hospitals for their reasonable costs, 42 U.S.C. §§1395f(b); 1395x(v)(1)(A); 20 C.F.R. §§405.401, 405.402, 405.451, 405.454. For some inexplicable reason, the District Court totally ignored this statute and the regulations in its decision.[6]

The Overton standard of "law to apply" comes from the Senate Judiciary Committee Report (S. Rep. No. 752, 79th Cong., 1st Sess. (1945)) accompanying the bill which became the APA. Therefore, it must be interpreted in light of all of the APA's legislative history, particularly the proceedings in the Senate. If this is done, it becomes clear that any abuse of discretion was intended to be reviewable.[7] Particularly illuminating in

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6. In the last paragraph of its decision (322a), the Court states that the issue of the shifting of costs "must await the determination of the amount of reimbursement." However, this statement is not made in the context of reviewability. Moreover, as shown in Point II, infra, p. 26, it is clear now that hospitals will not be reimbursed the total interest on working capital loans necessitated by conversion to New PIP.

7. In Scanwell Laboratories, Inc. v. Shaffer, 424 F.2d 859 (D.C. Cir. 1970), for example, the Court found that the award of a government contract, a traditional area of agency discretion, was judicially reviewable. "[W]hile review is not granted for action 'by law committed to agency discretion,' as noted in section 701(a)(2), review is expressly provided for when there is an abuse of that discretion...." Id. at 874.

Berger takes the same approach: "serious constitutional problems are raised if phrases such as 'in his judgment'

(cont. footnote)

this respect is the following exchange which took place during the Senate proceedings between Senator McCarran, Chairman of the Senate Judiciary Committee and Senator Donnell.

> MR. DONNELL [Senator from Missouri] I should like to ask the distinguished Senator a question. Section 10 of the bill recites in part that -
>
> > Except so far as (1) statutes preclude judicial review or (2) agency action is by law committed to agency discretion - (a) Right of review: Any person suffering legal wrong because of any agency action, or adversely affected or aggrieved by such action within the meaning of any relevant statute, shall be entitled to judicial review thereof.
>
> It has occurred to me that the contention might be made by someone in undertaking to analyze this measure that in any case in which discretion is committed to an agency, there can be no judicial review of action taken by the agency. The point to which I request the Senator to direct his attention is this: In a case in which a person interested asserts that, although the agency does have a discretion vested in it by law, nevertheless there has been abuse of that discretion, is there any intention on the part of the framers of this bill to preclude a person who claims abuse of discretion from the right to have judicial review of the action so taken by the agency?

(cont. footnote 7)

or 'to his satisfaction' are read to foreclose judicial review. To begin with, due process demands that there exists the necessary basis for administrative action - for example, it must be supported by evidence." 65 Col. L. Rev. at 71.

MR. MC CARRAN. [Senator from Nevada] Mr. President, let me say, in answer to the able Senator that the thought uppermost in presenting this bill is that where an agency without authority or by caprice makes a decision, then it is subject to review.

* * * *

MR. DONNELL. But the mere fact that a statute may vest discretion in an agency is not intended, by this bill, to preclude a party in interest from having a review in the event he claims that there has been an abuse of that discretion. Is that correct?

MR. MC CARRAN. It must not be an arbitrary discretion. It must be a Judicial discretion; it must be a discretion based on sound reasoning.

APA Leg. History, *supra* at 310-11 (emphasis added).

The application of the New PIP system to the hospitals is clearly such a complete disregard of law and the public welfare as to constitute the kind of abuse of discretion which the APA was enacted to prevent. At a time when Congress is attempting to develop programs which will curb rising health costs and guarantee adequate health care to all citizens,[8] it would be

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8. In the National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, 88 Stat. 2225, Congress specifically found that

> (1) [t]he achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government. Section 2(a).

deplorable to permit the executive branch to implement a system which would produce completely opposite results. The uncontradicted evidence demonstrates that the conversion of hospitals on Old PIP to New PIP will either increase the cost of hospital care or force the elimination of vital services. (pp. 10-11, _supra_).

POINT II

THE PROPOSED APPLICATION OF THE NEW PIP REIMBURSEMENT REGULATION TO THE CLASS WILL VIOLATE THE MEDICARE ACT AND REGULATIONS

(i) The Repeal of the Old PIP Reimbursement System Violates The Medicare Requirement that Providers be Reimbursed the Reasonable Cost of Services

The Medicare Act and regulations require that providers be reimbursed the "reasonable cost" of services they render. 42 U.S.C. §§1395f(b), 1395x (v)(1)(A); 20 C.F.R. §§405.401, 405.402, 405.451, 405.454. By failing to make provision for hospital working capital, respondents are violating these sections of law.

The "reasonable cost" of services, which includes indirect as well as direct costs, is statutorily defined as

> the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services,.. determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services.... 42 U.S.C. §1395x (v)(1)(A).

Pursuant to this directive, the Secretary has classified as reasonable costs all

> necessary and proper expenses of an institution in the production of services, including normal standby costs.... 20 C.F.R. §405.451(a). See also 20 C.F.R. §405.451(a).

> Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity. 20 C.F.R. §405.451(b)(2).

A hospital, like any other business institution, requires adequate working capital. Supplies, such as food and drugs, must be obtained and personnel hired before patients are admitted. Both James Ingram, an expert in hospital reimbursement, and Irwin Birnbaum, Deputy Director for Fiscal Affairs for Montefiore Hospital, which is the largest provider of Medicare services in the country, testified that working capital is part of the reasonable cost of running a hospital (69a, 104a, 105a, 116a, 117a). Even John Jansak, Chief of the Provider Reimbursement Policy Branch of HEW and the government's only witness, conceded that working capital is a necessity for a hospital (224a).

Further evidence that working capital is a proper element of a hospital's reasonable cost comes from the fact that it is recognized as such by the two other major national third party payors, Blue Cross and Medicaid. As the uncontradicted evidence shows, both of these systems make express provision for hospital working capital by means of cash advances (74a, 88a, 91a).

For example, Mr. Birnbaum testified that Blue Cross and Medicaid each have on deposit with Montefiore about 2.25 million dollars (117a). Philip C. Abrams, Executive Director of the Jewish

Hospital and Medical Center of Brooklyn, testified that his hospital receives an advance of $150,000 from Blue Cross and a 2.5 million dollar advance from Medicaid (148a, 149a). Leo Hellman, Director of Fiscal Services for Peninsula Hospital Center, testified that his hospital has on deposit a $300,000 Blue Cross advance and a $550,000 Medicaid advance (173a). Peter B. Terenzio, Executive Vice President of Roosevelt Hospital, testified that Blue Cross has advanced Roosevelt approximately $900,000 and Medicaid has advanced approximately $2.8 million for use as working capital (181a, 182a).

From 1966, the date of the implementation of the Medicare program, until the promulgation of New PIP, HEW also recognized working capital as an element of reasonable cost.

HEW promulgated two provisions as part of the original Medicare regulations which were designed to increase providers' flow of capital. The first of these was a 2% allowance "[i]n lieu of specific recognition of other costs" that was intended to compensate a provider for those "various elements which are germane to costs of services for beneficiaries" which HEW felt were not subject to precise measurement. 20 C.F.R. §405.428; 31 Fed. Reg. 14816 (1966). The other was a payment system entitled "current financing" under which providers were paid an amount designed to partially compensate them for the average delay entailed in the processing of bills, 20 C.F.R. §405.454(g);

31 Fed. Reg. 14820 (1966).[9]

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9. The 2% cost allowance was primarily intended to compensate providers for the higher cost incurred in providing services for persons aged 65 and over. Hearings on Reimbursement Guidelines for Medicare Before the Senate Committee on Finance, 89th Cong., 2d Sess. at 72 (1966) (hereinafter the "Hearings"). However, this allowance was also aimed at reimbursing hospitals for the use of their capital in providing Medicare services and had the effect of making additional income available for working capital. As specifically stated by Robert M. Ball, then Commissioner of Social Security, in testimony at the Hearings:

> It is the established practice of a significant number of large third party purchasers to include in payment for cost of services a factor in the form of an allowance to cover various elements not specifically recognized in the formula or not precisely measured. The 2-percent allowance provided for in our principles does the same thing. It is not a bonus but a part of basic cost.
>
> The allowance is limited to an amount which might be justified as a minimum return for the use of equity capital, as discussed earlier. Hearings at 56.

Although the 2% cost allowance was not included in the regulations solely for the purpose of providing working capital, the "current financing" provisions were. This intent is apparent from the reasons advanced for this system by HEW at the hearings.

> "Prior to rendering services and submitting bills for such services, providers as a matter of course need to make cash outlays from their own funds for necessary equipment and supplies, and for the services of supporting personnel. In the case of new providers and providers desiring to institute new or improved services, such outlays place a special burden on their finances.
>
> "The intermediary will process interim payments for services rendered to beneficiaries as expeditiously as possible. Nevertheless, whatever the billing schedule of the provider and however promptly the intermediary processes the request for payment, there is a period of time during which the provider

[Footnote continued on following page]

Even Mr. Jansak, despite his continual attempts to avoid giving a direct answer, acknowledged that the "2% allowance" and "current financing" were adopted to provide hospitals with working capital (256a-258a).

Unfortunately, neither the 2% cost differential nor the provision for current financing completely solved the problem of hospital cash flow, principally because both still tied reimbursement to individual patient bills.

> has some of its funds tied up in services to beneficiaries for which the program is obligated to pay but has not yet paid.
>
> "In recognition of the fact that providers must make such outlays of funds in order to render services to beneficiaries of the program, it is appropriate that <u>the health insurance program should provide funds to providers at the point in time when such outlays are necessary</u>. This would place providers in a stronger position by reducing the burden upon the provider of financing the lag between outlays and collection for services." Hearings at 35-6 (emphasis added).

These principles were further elaborated in the statement of Alanson W. Willcox, General Counsel of the Social Security Administration, to the Senate Finance Committee.

> Supplies must be bought before they can be used, and wages must be paid at regular intervals, yet hospital bills are usually rendered only on discharge of a patient or after a considerable hospital stay.... It is this delay, and the corresponding cost to the provider <u>for the use of working capital</u>, that the provision in question is designed to avoid. Hearings at 94.

Consequently, a third approach, Old PIP, was tried. Mr. Ingram was the only witness at the hearing who had any personal knowledge of the origin of Old PIP. Not only was he a Blue Cross reimbursement executive in 1968, but he was also consulted about the implementation of Old PIP by the Social Security Administration, (55a, 56a, 58a). Mr. Ingram confirmed that in fact, Old PIP had been adopted for the express purpose of eliminating the severe cash flow problems which hospitals had been experiencing under the traditional Medicare billing system (60a) and which were not being met by the "2% allowance" or "current financing."[10]

In the New York City area approximately 85% of hospital reimbursement comes from the three major third party payors, Medicare, Medicaid and Blue Cross. All three of these payment systems are cost based and make no provision for the generation of profit. As a result, the hospitals are limited in their ability to generate additional capital which can be used to meet working capital needs and the third party reimbursers must make separate provision to insure the adequate flow of cash to these providers. Furthermore, many of these hospitals incur extraordinary losses when they provide emergency and other outpatient services to the residents of New York. All of this is a continual drain on their resources (70a, 71a). In light of these facts, it is unrealistic to argue that working capital is not an element of reasonable

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10. Subsequent to the adoption of Old PIP, which was successful in meeting the cash flow needs of the New York City hospitals, the 2% cost allowance and current financing provisions were repealed. 34 Fed. Reg. 9927 (1969); 38 Fed. Reg. 14093 (1973).

cost for the voluntary hospitals in New York.

(ii) The Repeal of the Old PIP Reimbursement System Violates the Medicare Prohibition Against The Shifting of Medicare Costs to Non-Medicare Beneficiaries.

The Medicare Act provides

> that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs.... 42 U.S.C. §1395x(v)(1)(A).

The Medicare regulations also prohibit the shifting of Medicare costs to non-Medicare beneficiaries. 20 C.F.R. §§405.402, 405.403, 405.405, 405.451(b). This principle will be violated both in the situation where a hospital borrows money to replace the working capital funds lost through conversion to the New PIP system as well as in the situation where it expends its own funds to make up the loss.

One reason for this violation is that Medicare will reimburse a hospital only for interest costs in an amount equal to that percentage of the hospital's patient days represented by Medicare patient days. 20 C.F.R. §405.453. Thus, if a hospital borrows money to make up for the loss in working capital arising from the conversion to New PIP as many will do (95a) and, if 45% of the hospital's patient days are Medicare patient days, HEW will only reimburse 45% of the interest on the working capital loan. The

remainder of the interest will have to be picked up by the hospital's non-Medicare patients, primarily its self-pay patients.[11]

Hospitals cannot avoid shifting increased costs to non-Medicare beneficiaries simply by limiting their borrowing to an amount equal to the cost of Medicare goods and services since such goods and services are not acquired on an individual patient basis, but for the hospital as a whole. It would clearly be wasteful, for example, to have separate nursing staffs or intensive care units for Medicare and non-Medicare beneficiaries.

A clear and unavoidable result then of implementing the New PIP reimbursement regulation will be an improper shifting of health care costs in violation of a fundamental principle of the Medicare program.

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11. It was to avoid violating this section of the Medicare Act, 42 U.S.C. §1395x(v)(1)(A), that Commissioner Ball included provision for working capital in his original promulgation of the Medicare regulations in 1966.

> . . .our theory on this is that unless they get that money at the time they make the expenditure, they will have to either borrow working capital, on which we would pay the interest, or if they use their own money for that, they are actually losing the equivalent of interest on that money while they are making expenditures before we pay it. The result is, Senator, that I believe that we would be violating one of the main principles of the law which says we are to pay the full cost, so that younger people don't bear any of the cost of older people. Hearings at 64.

Although Judge Metzner stated that "the resolution of the question of whether Medicare costs will be transferred to non-Medicare patients must await the determination of the amount of reimbursement" (322a), both the Medicare regulations and Jansak's testimony (270a)[12] make it quite clear that Medicare will not reimburse the hospitals for the full amount of their interest on working capital loans. Therefore, the shifting of costs contrary to the specific terms of the statute is plainly involved in this case now.

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12. "Q In any event, it is your opinion then, is it not, that the payment of 100 percent of the interest costs that might be occasioned by this change in regulation, would be something inconsistent with the present reimbursement system?

"A [by Mr. Jansak] It would be inconsistent with the way the regulations are written." (270a)

THE REGULATION REPEALING THE OLD PIP MEDICARE REIMBURSEMENT SYSTEM IS ARBITRARY, CAPRICIOUS AND AN ABUSE OF DISCRETION

The opinion below plainly implies that even if the Court had found the repeal of Old PIP reviewable, it would have sustained the promulgation of the New PIP regulation. The reasoning seems to be that administrative action can be sustained on a mere statement of reasons without any examination as to their adequacy or support in the administrative record. This position is clearly at odds with existing legal standards.

The APA, 5 U.S.C.§706(2), provides that a reviewing court shall

> hold unlawful and set aside agency action, findings and conclusions found to be - (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law....

Under the arbitrary and capricious standard,[13] the reasons given by the agency for its action must be supported by the entire administrative record. Camp v. Pitts, 411 U.S. 138, 142-143 (1973); Citizens

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13. The government's actions are challenged under the arbitrary and capricious standard. However, under recent cases, the standard of proof involved for an arbitrary and capricious determination in informal rule-making may not be very different from that required in a finding of a lack of "substantial evidence". 5 U.S.C. §706(2)(E). Friendly, Some Kind of Hearing, 123 U. Pa. L.Rev. 1267, 1313-14 (1975). Associated Industries of New York State, Inc. v. U.S. Dept. of Labor, 487 F.2d 342, 349-50 (2d Cir. 1973).

to Preserve Overton Park v. Volpe, supra, at 419; Securities & Exchange Commission v. Chenery Corp., 318 U.S. 80, 87, 93-94 (1943). The fact that informal rule-making is involved, as in the present case, does not exempt an agency from this requirement.

> Indeed the very absence of a detailed record of the type that would be made if an evidentiary hearing were held makes it advisable for the agency, in lieu thereof, to provide a thorough and comprehensible statement of the reasons for its decision. Where the agency's "finding is not sustainable on the administrative record made, then the...decision must be vacated and the matter remanded to [the agency] for further consideration." National Nutritional Foods Ass'n v. Weinberger, 512 F.2d 688, 701 (2d Cir. 1975) quoting Camp v. Pitts, supra at 143.

In its examination of the regulation repealing Old PIP, the District Court limited itself to a determination of whether an adequate statement of reasons had been given in support of the new regulation (320a-321a). There was no consideration of whether there was sufficient support for these reasons in the administrative record.

The District Court found that the government had given three reasons for supporting the adoption of the New PIP regulation:

> 1) "Careful consideration of the introduction of an average 3-week payment lag into the PIP method demonstrated that such a lag compares favorably with the average lag in payment experienced by providers reimbursed under regular interim payment procedures."
>
> 2) "[U]nder old PIP the weekly payments were going to the hospitals long before the latter were paying their vendors."
>
> 3) "[S]tretching out the payments within the permissible period was accruing interest for the benefit of the Medicare fund." (321a)

None of these reasons are supported by the record before the District Court.

No Inconsistency

The first reason, that Old PIP was not consistent with traditional billing (215a, 216a), is hardly a reason at all.

Nothing in the Medicare Act or regulations suggests that there must be uniformity of payment dates. In fact, the phrase "not less often than monthly" in 42 U.S.C. §1395g suggests the opposite. Obviously, the Old PIP system was different from the traditional billing procedure and this, in fact, is the very reason it was enacted in the first place. The government has known this since 1968 and therefore, consistency cannot have been the reason why a change was made in 1975. Furthermore, according to Jansak's own testimony, the New PIP system will not be consistent with traditional billing practices either, since New PIP will have a three week lag while under the traditional system there is an average 30 day lag (203a).

Respondents have suggested that since most of the hospitals in the country are able to work under the traditional billing or New PIP systems, the same should be true for New York City hospitals (215a-218a). This overlooks the fact that the voluntary hospitals in New York City are in a vastly different position from the hospitals in other parts of the country. Contrary to the situation in other parts of the country, most of the billing by New York hospitals is on a <u>cost</u> basis. About ~~98%~~ 85% of the hospital's income comes from Blue Cross, Medicare and Medicaid. Each of these third party payors reimburses hospitals on the basis of the cost of providing the service. This makes it imposible for the hospitals to

generate any working capital. In addition, New York hospitals operate extensive ambulatory care facilities, i.e., emergency rooms and clinics, which create "incredible deficits with serious cash flow problems" (60a). These facilities are the only source of health care for New York's indigent and working poor who cannot afford the cost of private physicians.

Speed of Payment

The District Court's second basis for upholding the validity of the new regulation was Jansak's testimony that the hospitals were being paid under Old PIP long before they paid their vendors (321a). The length of time that a hospital may take to pay its vendors is completely irrelevant to the issue before the Court. It is surely not unreasonable for the hospitals to ask to be paid promptly after they furnish the services. In relying on the time it takes to pay vendors as a reason, the Court was obviously assuming that any hospital which was delaying payment to its vendors for more than three weeks would not be injured under New PIP. This ignores the uncontradicted testimony that the delay in hospital payments is so great right now under the Old PIP system that the additional delay caused by the new system would either cause vendors to refuse to sell needed materials to the hospitals, thereby jeopardizing the quality of services (170a), or would raise vendor prices which would in turn increase the cost of hospital care (100a-101a, 180a-181a). It also ignores the fact that hospital payrolls which represent approximately 72% of operating costs are generally paid on a weekly

or bi-weekly basis (93a, 131a, 136a, 148a, 175a) which is inconsistent with New PIP.

<u>Medicare Trust Fund</u>

It is unclear on what basis the District Court concluded that New PIP would produce interest for the Medicare trust fund. Although Jansak did testify that it would (207a, 218a), there was also unrefuted testimony that the new system would create interest expenses on working capital loans and higher vendor prices (100a-101a, 109a, 113a, 170a, 181a). These, in turn, would cause a drain on the fund. No comparison of the potential loss or gain to the trust fund was presented to the court,[14] and Jansak testified that the only studies examined by HEW related to traditional billing time (275a).

It was therefore improper for Judge Metzner to have assumed that the repeal of Old PIP would create a net gain in the fund's assets. In effect, he took judicial notice of a fact which is only proper if the fact is

> not subject to reasonable dispute in that it is either (1) generally known within the territorial jurisdiction of the trial court or (2) capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned. Federal Rules of Evidence, Rule 201(b).

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14. In fact, when the Assistant United States Attorney attempted to introduce evidence into the record on the workings of the trust fund, the Court refused to allow it on the grounds that the Court would "assume the longer they [the trust fund] can hold on to the money, the greater interest they have on it" (225a).

There is nothing to indicate that either of the criteria in the Federal Rules exists. On the contrary, any determination of the effect of the repeal of Old PIP on the trust fund would require a complicated economic analysis including a projection of future hospital costs.

<u>The administrative record does not support promulgation of the new regulation.</u>

Presumably, the administrative record consists of comments received on the proposed regulation, which were acknowledged by Jansak to be generally "unfavorable and critical" (214a),[15] and studies on the traditional billing time (275a). There is no specific study "for the purpose of analyzing whether or not the PIP system should be changed" (275a-276a). Thus there is no factual basis in the record for the arguments offered by the government and accepted by the District Court to the effect that (1) the hospitals can and should absorb the additional delay inherent in New PIP and (2) New PIP would cause a gain to the Federal trust fund. The record therefore cannot serve as the basis for upholding HEW's action. <u>Citizens to Preserve Overton Park v. Volpe</u>, <u>supra</u>. The same is true of an additional reason in support of New PIP offered by the government at the hearing - that neither Blue Cross nor Medicaid had anything similar to PIP but instead relied on the traditional billing method (217a).[16]

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15. These unfavorable comments come from the organizations and institutions most familiar with hospital reimbursement, namely, the national hospital associations, individual hospitals and Blue Cross (213a-214a).

16. As shown in Point II, all of the evidence introduced into the record regarding payments by Blue Cross and Medicaid demonstrates

[Footnote continued on following page]

The only reason for the promulgation of the new regulation considered in the administrative record is that New PIP would be more consistent with traditional billing than Old PIP.[17] As has already been shown, this is not really a reason at all but, if anything, merely a description of the new system. Therefore, since "the grounds upon which the agency acted in exercising its powers were [not] those upon which its action can be sustained," the new regulation should be invalidated. Securities & Exchange Commission v. Chenery Corp., 318 U.S. at 95.

If the Court feels, however, that it is necessary to have the traditional billing studies and unfavorable comments comprising the administrative record examined, this matter must be remanded to the District Court. Camp v. Pitts, supra, at 142-143; Silva v. Lynn, 482 F.2d 1282, 1283 (1st Cir. 1973); Citizens to Preserve Overton Park v. Volpe, supra, at 419-420.

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that both of these third party payors leave money on deposit with the hospitals for the express purpose of meeting working capital needs (71a-75a).

Jansak, who was the government's expert (194a), did not even know whether the Blue Cross Associations had any accelerated payment mechanism (271a).

17. HEW cannot justify the regulation on the basis of its "experience" unless the experience has been made part of the record before the reviewing court. National Nutritional Foods Association v. Weinberger, supra at 701, n. 11.

POINT IV

THE HOSPITALS WILL SUFFER IRREPARABLE INJURY UNLESS AN INJUNCTION IS GRANTED

The uncontradicted evidence clearly shows that implementation of the New PIP reimbursement system will create serious and insurmountable financial problems for the hospitals. The implementation of New PIP requires respondents to withhold from appellants approximately $28,371,300 representing three weeks of cash flow by May 31, 1976 (279a-290a, 110a). When the amount to be withheld from the intervenor hospitals is included, this figure rises to approximately $34,230,600. While the extension of the date for full implementation until May 31, 1976 might delay some of the disastrous consequences of the conversion, it will, in no way, remove them. The hospitals will still be denied three weeks of working capital necessary for their proper operation.[18]

While most of the hospitals will have to try to borrow to make up for this lost cash, there will be some hospitals which will be unable to do so (95a, 101a).[19] Those hospitals which will be

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18. Even the Secretary of HEW recognized the "extraordinary cash flow problems" which adherence to the September 15, 1975 implementation date would have created for the hospitals on Old PIP, "especially those located in large urban centers" (40 Fed. Reg. 40192 (1975) at Appendix 286a).

19. Philip C. Abrams, Executive Director of the Jewish Hospital and Medical Center of Brooklyn, testified that his hospital, a 636 bed hospital serving Bedford-Stuyvesant, Crown Heights and Fort Greene, would lose approximately $1,600,000 in cash flow (representing three weeks of PIP payments) if it were forced to convert to the New PIP system (147a). Since the hospital has a current net working capital deficit of approximately $5,000,000, it would

[Footnote continued on following page]

unable to borrow the additional funds necessitated by the conversion to New PIP will have to try to delay payments to their vendors which,

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be unable to borrow additional funds to make up this new loss in cash flow (145a, 148a). Mr. Abrams stated that the banks, in reaching the decision not to lend additional funds, had already taken into consideration the revenues generated by the three major third party payors, namely Medicare, Medicaid and Blue Cross (148a). Since it did not appear likely that the hospital would be able to delay payments either to its unions or major vendors, Mr. Abrams indicated that he would have no choice but to cut back on vital hospital services (147a, 149a, 150a).

Leo Hellman, Director of Fiscal Services for Peninsula Hospital Center, a 270 bed hospital in Far Rockaway, testified that the effect of the New PIP system on his hospital would be "an absolute disaster" (169a). Since the hospital's present weekly PIP payment is $147,500, it would lose $442,500 in cash flow by May 31, 1976 (168a). Mr. Hellman explained that Peninsula would be unable to borrow the money because at the present time it has an outstanding working capital loan of $1.2 million which contains a provision prohibiting any further borrowing (169a, 170a). In order to prevent the hospital from having to cut back on services, 60% of which are rendered to Medicare patients, Mr. Hellman felt that he would

> probably have to extend our vendor payments which presently is at 110 days to something well over six or seven months which in turn would probably mean a cut off of supplies. If that did not happen, if they were kind enough to give it to us, it would mean a substantial increase in price for all our goods.
>
> * * * *
>
> In addition, we would probably have to hold back payments from our own union from the employees which I dare say in past years has caused a lot of rumbling and could precipitate a walkout. We would probably have to hold back payments for the Federal Government for withholding taxes. (170a).

Peter B. Terenzio, Executive Vice President of Roosevelt Hospital, which serves the west side of Manhattan, testified that his hospital would not be able to borrow the $650,000 necessary to make up for the three weeks cash flow loss that would be produced by the New PIP system (181a). The reason for this is that the hospital has no further collateral which can be offered as security (181a) and a negative working capital position in excess of $2.2 million (179a). Terenzio indicated that the burden of the

[Footnote continued on following page]

as the uncontradicted testimony shows, will result in higher prices and increased hospital costs. In many cases the hospitals will have no choice but to cut back on vital services (147a, 149a, 150a, 170a, 171a).

Even in the case of those hospitals that are able to borrow, however, Medicare will reimburse them only for the portion of the interest costs equal to that percentage of their patient days represented by Medicare patient days. 42 U.S.C. §1395x(v)(1)(A); 20 C.F.R. §§405.402, 405.403, 405.405, 405.453. Thus, a large portion

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loss in working capital would therefore have to be forced onto the hospital's vendors.

> We are at somewhere over 90 days, and creeping up to 120 and this would push, I'm sure, into 120 days because the outstanding receivables, 4.5, outstanding payables about $4.5 million, and this would add another $600,000 to that amount.
>
> * * * *
>
> We were sued by Con Ed, and had to make a nice settlement from Con Ed's point of view, and a disastrous one from ours.
>
> We compromised and agreed to pay current billings and work off the old debt of $800,000 at the rate of $100,000 a month tacked onto the current bill. We have to keep that up to date or they claim they will turn the lights off.
>
> * * * *
>
> I'm convinced that we are paying higher prices for some of the items because we are slow pay....
>
> Q. Higher price results in higher operating cost for you, don't they?
>
> A. Yes, sir. (180a, 181a).

of their interest costs will not be compensated for by Medicare. Judge Metzner took the position that the percentage of the interest which HEW would reimburse could not be determined at this time. This is clearly incorrect as we have shown in our discussion on the shifting of costs to non-Medicare beneficiaries (pp. 32-34, <u>supra</u>).

Neither Blue Cross nor Medicaid, the two other third-party payors, which together with Medicare supply almost ~~90%~~ 85% of the income of New York City hospitals (~~68a~~ 70a), will pick up the remaining interest on a hospital's working capital loan since their rates are determined prospectively, <u>i.e.</u>, prior to the year to which they apply. N. Y. Public Health Law §2807; 10 NYCRR Part 86.[20] Thus, the interest expense which will occur in 1976 due to the loans that will be necessitated by the conversion to New PIP will, in no way, be reflected in the 1976 reimbursement rate. Whatever part of that interest expense is not reimbursed by Medicare must somehow be absorbed by the hospitals, thereby necessitating the borrowing of even more money or the curtailing of services to the public.[21]

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20. In substance prospective reimbursement takes the hospitals' reimbursable operating expense figures for a base year two years prior to the rate year, and projects them forward to the rate year by the use of certain projections and indices. (For a discussion of the prospective reimbursement method see <u>Presbyterian Hospital v. Ingraham</u>, 48 AD 2d 491 (1st Dept. 1975).)

21. The Montefiore Hospital situation is illustrative of the disastrous effect the conversion to New PIP will have. Under the best of circumstances, this hospital will have to borrow more than $2,600,000 and pay interest at the rate of 8% or 9% per annum (110a). This would result in an increase in the cost of health care of about $216,000 per annum at this

[Footnote continued on following page]

Respondents suggest that Medicare would not be responsible for any injury resulting from the implementation of the New PIP system because the increased financial pressure which such implementation would entail would be only one of many affecting the hospitals (76a, 77a, 154a, 155a). However, this argument overlooks the fact that the injury complained of in this action is caused only by respondents' actions. As stated by Judge Metzner:

> This loan is being caused by your [Medicare's] action and nobody else's (243a).

In discussing the interest cost which would be incurred by the hospitals, Judge Metzner had stated earlier to the Government's witness:

> Why should they pass it on if you caused it? Why couldn't you pay for what you caused? That is what this case is all about (163a).

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institution. Moreover, despite the fact that the increased cost is due solely to the acts of Medicare, Medicare will pay only about 45% of the interest. Due to the manner in which prospective reimbursement operates, Blue Cross and Medicaid will not include the remainder of the interest expense in their rates until 1978. That portion of the interest expense of 1976 and 1977 which is not borne by Medicare will have to be absorbed by the hospital. The only way the hospital can do this is by eliminating services and by trying to extend the time in which it pays its vendors (113a). But, as has been demonstrated, delay in payment of vendors results in higher prices which further fuel the upward spiral of medical costs (100a, 101a, 170a, 181a).

CONCLUSION

For the reasons stated above, the Order of the District Court dismissing the complaint should be reversed.

Respectfully submitted,

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ADDENDUM

STATUTES AND REGULATIONS INVOLVED

The Administrative Procedure Act, 5 USC §701 provides in relevant part:

> §701. Application; definitions
>
> "(a) This chapter applies, according to the provisions thereof, except to the extent that--
>
> (1) statutes preclude judicial review; or
>
> (2) agency action is committed to agency discretion by law..."

The Administrative Procedure Act, 5 USC §706 provides:

> §706. Scope of review

"To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall--

> (1) compel agency action unlawfully withheld or unreasonably delayed; and
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be--
>
> (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
>
> (B) contrary to constitutional right, power, privilege, or immunity;
>
> (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;

(D) without observance of procedure required by law;

(E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or

(F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error."

The Social Security Act provides at 42 U.S.C. §1302:

§1302. Rules and regulations

"The Secretary of the Treasury, the Secretary of Labor, and the Secretary of Health, Education, and Welfare, respectively, shall make and publish such rules and regulations, not inconsistent with this chapter, as may be necessary to the efficient administration of the functions with which each is charged under this chapter."

The Medicare Act, 42 USC §1395 et seq. provides in relevant part:

§1395f

..."(b) The amount paid to any provider of services with respect to services for which payment may be made under this part shall, subject to the provisions of section 1395e of this title, be -

(1) the lesser of (A) the reasonable cost of such services, as determined under section 1395x(v) of this title, or (B) the customary charges with respect to such services; or

(2) if such services are furnished by a public provider of services free of charge or at nominal charges to the public, the amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such reasonable cost which the Secretary finds will provide fair compensation to such provider for such services."

§ 1395g. Payment to providers of services

"The Secretary shall periodically determine the amount which should be paid under this part to each provider of services with respect to the services furnished by it, and the provider of services shall be paid, at such time or times as the Secretary believes appropriate (but not less often than monthly) and prior to audit or settlement by the General Accounting Office, from the Federal Hospital Insurance Trust Fund, the amounts so determined, with necessary adjustments on account of previously made overpayments or underpayments; except that no such payments shall be made to any provider unless it has furnished such information as the Secretary may request in order to determine the amounts due such provider under this part for the period with respect to which the amounts are being paid or any prior period."

§ 1395x(v)(1)(A)

"The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the

services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive."

The Medicare Regulations governing reimbursement (20 CFR 405.401 et seq.) provide in relevant part:

§ 405.401 Introduction.

(a) Under the health insurance program for the aged and disabled, the amount paid to any provider of services—i.e., hospital, skilled nursing facility, or home health agency—for the covered services furnished to beneficiaries is required by section 1814(b) and section 1833(a)(2) of the Act to be the reasonable cost of such services subject to the provisions of §§ 405.455 and 405.460.

(b) These principles of reimbursement and the related policies described in this subpart establish the guidelines and procedures to be used by institutional providers, fiscal intermediaries, and the Social Security Administration in determining reasonable cost.

(c) The principles of reimbursement are to be applied on behalf of the program by public and private organizations and agencies acting as fiscal intermediaries in the payment of claims. These organizations and agencies are selected after nomination by groups or associations of hospitals. Skilled nursing facilities and home health agencies may similarly nominate such intermediaries. The fiscal intermediaries are responsible for paying the bills of beneficiaries for covered services received in participating hospitals and other institutions under the medicare program. A provider may deal directly with the Social Security Administration, in which case the same principles are to be used in making payment for services.

(d) In consideration of the wide variations in size and scope of services of providers and regional differences that exist, the principles are flexible on many points. They offer certain alternatives and options designed to fit individual circumstances and to allow time for those providers who do not already collect the statistical and financial data necessary for the reporting of costs to develop the necessary records.

(e) An important role of the fiscal intermediary, in addition to claims processing and payment, and other assigned responsibilities, is to furnish consultative services to providers in the development of accounting and cost-finding procedures which will assure them equitable payment under the program.

§ 405.402 Cost reimbursement; general.

(a) In formulating methods for making fair and equitable reimbursement for services rendered beneficiaries of the program, payment is to be made on the basis of current costs of the individual provider, rather than costs of a past period or a fixed negotiated rate. All necessary and proper expenses of an institution in the production of services, including normal standby costs, are recognized. Furthermore, the share of the total institutional cost that is borne by the program is related to the care furnished beneficiaries so that no part of their cost would need to be borne by other patients. Conversely, costs attributable to other patients of the institution are not to be borne by the program. Thus, the application of this approach, with appropriate accounting support, will result in meeting actual costs of services to beneficiaries as such costs vary from institution to institution. However, payments to providers of services for services rendered health insurance program beneficiaries are subject to the provisions of §§ 405.455 and 405.460.

(b) Putting these several points together, certain tests have been evolved for the principles of reimbursement and certain goals have been established that they should be designed to accomplish. In general terms, these are the tests or objectives:

(1) That the methods of reimbursement should result in current payment so that institutions will not be disadvantaged, as they sometimes are under other arrangements, by having to put up money for the purchase of goods and services well before they receive reimbursement.

(2) That, in addition to current payment, there should be retroactive adjustment so that increases in costs are taken fully into account as they actually occurred, not just prospectively.

(3) That there be a division of the allowable costs between the beneficiaries of this program and the other patients of the provider that takes account of the actual use of services by the beneficiaries of this program and that is fair to each provider individually.

(4) That there be sufficient flexibility in the methods of reimbursement to be used, particularly at the beginning of the program, to take account of the great differences in the present state of development of recordkeeping.

(5) That the principles should result in the equitable treatment of both nonprofit organizations and profitmaking organizations.

(6) That there should be a recognition of the need of hospitals and other providers to keep pace with growing needs and to make improvements.

(c) As formulated herein, the principles give recognition to such factors as depreciation, interest, bad debts, educational costs, compensation of owners, and an allowance for a reasonable return on equity capital of proprietary facilities. With respect to allowable costs some items of inclusion and exclusion are:

(1) An appropriate part of the net cost of approved educational activities will be included.

(2) Costs incurred for research purposes, over and above usual patient care, will not be included.

(3) Grants, gifts, and income from endowments will not be deducted from operating costs unless they are designated by the donor for the payment of specific operating costs.

(4) The value of services provided by nonpaid workers, as members of an organization (including services of members of religious orders) having an agreement with the provider to furnish such services, is includable in the amount that would be paid others for similar work.

(5) Discounts and allowances received on the purchase of goods or services are reductions of the cost to which they relate.

(6) Bad debts growing out of the failure of a beneficiary to pay the deductible, or the coinsurance, will be reimbursed (after bona fide efforts at collection).

(7) Charity and courtesy allowances are not includable, although "fringe benefit" allowances for employees under a formal plan will be includable as part of their compensation.

(8) A reasonable allowance of compensation for the services of owners in profitmaking organizations will be allowed providing their services are actually performed in a necessary function.

(d) In developing these principles of reimbursement for the health insurance program, all of the considerations inherent in allowances for depreciation were studied. The principles, as presented, provide options to meet varied situations. Depreciation will essentially be on an historical cost basis but since many institutions do not have adequate records of old assets, the principles provide an optional allowance in lieu of such depreciation for assets acquired before 1966. For assets acquired after 1965, the historical cost basis must be used. All assets actually in use for production of services for title XVIII beneficiaries will be recognized even though they may have been fully or partially depreciated for other purposes. Assets financed with public funds may be depreciated. Although funding of depreciation is not required, there is an incentive for it since income from funded depreciation is not considered as an offset which must be taken to reduce the interest expense that is allowable as a program cost.

(e) [Reserved]

(f) A return on the equity capital of proprietary facilities is an allowable cost in profit-making organizations. The rate of return may not exceed one and one-half times the average long-term rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund.

(g) The Social Security Administration is authorized to issue temporary instructions modifying the provisions of this subpart to the extent it finds appropriate for cost reporting periods ending after June 30, 1973, in order to implement sections 201 (Coverage for Disability Beneficiaries Under Medicare) and 2991 (Chronic Renal Disease Considered to Constitute Disability) of Pub. L. 92-603. In so doing, rules may be developed for establishing limits on costs and services above which reimbursement shall be made only upon appropriate justification

[31 F.R. 14808, Nov. 22, 1966, as amended at 35 FR 12330, Aug. 1, 1970; 38 FR 17211, June 29, 1973; 39 FR 20165, June 6, 1974]

§ 405.103 Apportionment of allowable costs.

(a) Consistent with prevailing practice where third-party organizations pay for health care on a cost basis, reimbursement under the title XVIII health insurance program involves a determination of (1) each provider's allowable costs for producing services, and (2) the share of these costs which is to be borne by title XVIII. The provider's costs are to be determined in accordance with the principles reviewed in the preceding discussion relating to allowable costs; the share to be borne by title XVIII is to be determined in accordance with principles relating to apportionment of cost.

(b) In the study and consideration devoted to the method of apportioning costs, the objective has been to adopt methods for use under title XVIII of the Act that would, to the extent reasonably possible, result in the program's share of a provider's total allowable costs being the same as the program's share of the provider's total services. This result is essential for carrying out the statutory directive that the program's payments to providers should be such that the costs of covered services for beneficiaries would not be passed on to nonbeneficiaries, nor would the cost of services for nonbeneficiaries be borne by the program.

(c) A basic factor bearing upon apportionment of costs is that title XVIII beneficiaries are not a cross section of the total population. Nor will they constitute a cross section of all patients receiving services from most of the providers that participate in the program. Available evidence shows that the use of services by persons age 65 and over differs significantly from other groups. Consequently, the objective sought in the determination of the title XVIII share of a provider's total costs means that the methods used for apportionment must take into account the differences in the amount of services received by patients who are beneficiaries and other patients served by the provider.

(d) The method of cost reimbursement most widely used at the present time by third-party purchasers of inpatient hospital care apportions a provider's total costs among groups served on the basis of the relative number of days of care used. This method, commonly referred to as average per diem cost, does not take into account variations in the amount of service which a day of care may represent and thereby assumes that the patients for whom payment is made on this basis are average in their use of service.

(e) In considering the average per diem method of apportioning cost for use under the program, the difficulty encountered is that the preponderance of presently available evidence strongly indicates that the over-65 patient is not typical from the standpoint of average per diem cost. On the average he stays in the hospital twice as long and therefore the ancillary services that he uses are averaged over the longer period of time, resulting in an average per diem cost for the aged alone, significantly below the average per diem for all patients.

(f) Moreover, the relative use of services by aged patients as compared to other patients differs significantly among institutions. Consequently, considerations of equity among institutions are involved as well as that of effectiveness of the apportionment method under the program in accomplishing the objective of paying each provider fully, but only, for services to beneficiaries.

(g) A further consideration of long-range importance is that the relative use of services by aged and other patients can be expected to change, possibly to a significant extent in future years. The ability of apportionment methods used under the program to reflect such change is an element of flexibility which has been regarded as important in the formulation of the cost reimbursement principles.

(h) An alternative to the relative number of days of care as a basis for apportioning costs is the relative amount of charges billed by the provider for services to patients. The amount of charges is the basis upon which the cost of hospital care is distributed among patients who pay directly for the services they receive. Payment for services on the basis of charges applies generally under insurance programs where individuals are indemnified for incurred expense, a form of health insurance widely held throughout the Nation. Also, charges to patients are commonly a factor in determining the amount of payment to hospitals under insurance programs providing service benefits, many of which pay "costs or charges, whichever is less" and some of which pay exclusively on the basis of charges. In all of these instances, the provider's own charge structure and method of itemizing services for the purpose of assessing charges is utilized as a measure of the amount of services received and as the basis for allocating responsibility for payment among those receiving the provider's services.

(i) An increasing number of third-party purchasers who pay for services on the basis of cost are developing methods which utilize charges to measure the amount of services for which they have responsibility for payment. In this approach, the amount of charges for such services as a proportion of the provider's total charges to all patients is used to determine the proportion of the provider's total costs for which the third-party purchaser assumes responsibility. The approach is subject to numerous variations. It can be applied to the total of charges for all services combined or it can be applied to components of the provider's activities for which the amount of costs and charges are ascertained through a breakdown of data from provider's accounting records.

(j) For the application of the approach to components, which represent types of services, the breakdown of total costs is accomplished by "cost-finding" techniques under which indirect costs and nonrevenue activities are allocated to revenue producing components for which charges are made as services are rendered.

[31 F.R. 14809, Nov. 22, 1966]

§ 405.405 Payments to providers; general.

(a) The fiscal intermediaries will establish a basis for interim payments to each provider. This may be done by one of several methods. Where an intermediary is already paying the provider on a cost basis, the intermediary can adjust its rate of payment to an estimate of the result under the title XVIII principles of reimbursement. Where no organization is paying the provider on a cost basis, the intermediary can obtain the previous year's financial statement from the provider and, by applying the principles of reimbursement, compute or approximate an appropriate rate of payment. The interim payment may be related to the last year's average per diem, or to charges, or to any other ready basis of approximating costs.

(b) At the end of the period, the actual apportionment, based on the cost finding and apportionment methods selected by the provider, will determine the title XVIII reimbursement for the actual services provided to beneficiaries during the period.

(c) Basically, therefore, interim payments to providers will be made for services throughout the year, with final settlement on a retroactive basis at the end of the accounting period. Interim payments will be made as often as possible and in no event less frequently than once a month. The retroactive payments will take fully into account the costs that were actually incurred and settle on an actual, rather than on an estimated basis.

[31 FR 14810, Nov. 22, 1966, as amended at 38 FR 14093, May 29, 1973]

§ 405.451 Cost related to patient care.

(a) *Principle.* All payments to providers of services must be based on the reasonable cost of services covered under title XVIII of the Act and related to the care of beneficiaries. Reasonable cost includes all necessary and proper costs incurred in rendering the services, subject to principles relating to specific items of revenue and cost. However, for cost reporting periods beginning after December 31, 1973, payments to providers of services are based on the lesser of the reasonable cost of services covered under title XVIII of the Act and furnished to program beneficiaries or the customary charges to the general public for such services, as provided for in § 405.455.

(b) *Definitions*—(1) *Reasonable Cost.* Reasonable cost of any services must be determined in accordance with regulations establishing the method or methods to be used, and the items to be included. The regulations in this subpart take into account both direct and indirect costs of providers of services. The objective is that under the methods of determining costs, the costs with respect to individuals covered by the program will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by the program. These regulations also provide for the making of suitable retroactive adjustments after the provider has submitted fiscal and statistical reports. The retroactive adjustment will represent the difference between the amount received by the provider during the year for covered services from both title XVIII and the beneficiaries and the amount determined in accordance with an accepted method of cost apportionment to be the actual cost of services rendered to beneficiaries during the year.

(2) *Necessary and proper costs.* Necessary and proper costs are costs which are appropriate and helpful in developing and maintaining the operation of patient care facilities and activities. They are usually costs which are common and accepted occurrences in the field of the provider's activity.

(c) *Application.* (1) It is the intent of title XVIII of the Act that payments to providers of services should be fair to the providers, to the contributors to the health-insurance trust funds, and to other patients.

(2) The costs of providers' services vary from one provider to another and the variations generally reflect differences in scope of services and intensity of care. The provision in title XVIII of the Act for payment of reasonable cost of services is intended to meet the actual costs, however widely they may vary from one institution to another. This is subject to a limitation where a particular institution's costs are found to be substantially out of line with other institutions in the same area which are similar in size, scope of services, utilization, and other relevant factors.

(3) The determination of reasonable cost of services must be based on cost related to the care of beneficiaries of title XVIII of the Act. Reasonable cost includes all necessary and proper expenses incurred in rendering services, such as administrative costs, maintenance costs, and premium payments for employee health and pension plans. It includes both direct and indirect costs and normal standby costs. However, where the provider's operating costs include amounts not related to patient care, specifically not reimbursable under the program, or flowing from the provision of luxury items or services (that is, those items or services substantially in excess of or more expensive than those generally considered necessary for the provision of needed health services), such amounts will not be allowable. The reasonable cost basis of reimbursement contemplates that the providers of services would be reimbursed the actual costs of providing quality care however widely the actual costs may vary from provider to provider and from time to time for the same provider.

[31 FR 14816, Nov. 22, 1966, as amended at 37 FR 10354, May 20, 1972; 39 FR 10883, May 10, 1974]

§ 405.452 Determination of cost of services to beneficiaries.

(a) *Principle for cost reporting periods starting before January 1, 1972.* Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. To accomplish this apportionment, for cost reporting periods starting before January 1, 1972, the provider shall have the option of either of the two following methods:

(1) *Departmental Method.* The ratio of beneficiary charges to total patient charges for the services of each department is applied to the cost of the department, taking into account, to the extent pertinent, for services provided after June 30, 1969, an inpatient routine nursing salary cost differential. (See § 405.430 for definition and application of this differential.)

(2) *Combination Method.* The cost of "routine services" for program beneficiaries is determined on the basis of average cost per diem of these services, taking into account, to the extent pertinent, for services provided after June 30, 1969, an inpatient routine nursing salary cost differential (see § 405.430 for definition and application of this differential). To this amount is added the cost of ancillary services used by beneficiaries, determined by apportioning the total cost of ancillary services on the basis of the ratio of beneficiary charges for ancillary services to total patient charges for such services.

(b) *Principle for cost reporting periods starting after December 31, 1971.* Total allowable costs of a provider shall be apportioned between program beneficiaries and other patients so that the share borne by the program is based upon actual services received by program beneficiaries. For cost reporting periods starting after December 31, 1971, the methods of apportionment are defined as follows:

(1) *Departmental Method.* The ratio of beneficiary charges to total patient charges for the services of each ancillary department is applied to the cost of the department; to this is added the cost of routine services for program beneficiaries, determined on the basis of a separate average cost per diem for general routine patient care areas, taking into account, to the extent pertinent, an inpatient routine nursing salary cost differential (see § 405.430 for definition and application of this differential), and in hospitals, a separate average cost per diem for each intensive care unit, coronary care unit, and other special care inpatient hospital units.

(2) *Combination Method.* The cost of routine services for program beneficiaries is determined on the basis of a separate average cost per diem for general routine patient care areas, taking into account, to the extent pertinent, an inpatient routine nursing salary cost differential (see § 405.430 for definition and application of this differential), and in hospitals, a separate average cost per diem for the aggregate of intensive care, coronary care, and other special care inpatient hospital units. To this amount is added the cost of ancillary services used by beneficiaries, determined by apportioning the total cost of ancillary services excluding delivery room costs, on the basis of the ratio of beneficiary charges for ancillary services to total patient charges for such services excluding charges for delivery room.

(c) *Availability of apportionment methods for cost reporting periods starting after December 31, 1971.* For cost reporting periods starting after December 31, 1971, providers shall use the applicable apportionment method indicated as follows:

(1) *Hospitals having less than 100 beds.* Any hospital having less than 100 beds, certified and noncertified, on the first day of its cost reporting period must use the Combination Method of apportionment. Where the combined bed capacity of a hospital-skilled nursing facility complex is less than 100 beds, the Combination Method shall be used by both components.

(2) *Other hospitals.* Any hospital or hospital-skilled nursing facility complex having 100 or more beds, certified and noncertified, on the first day of its cost reporting period must use the Departmental Method of apportionment.

(3) *Skilled nursing facilities.* Skilled nursing facilities, regardless of bed size, must use the Combination Method of apportionment, except as specified in subparagraph (2) of this paragraph.

(d) *Definitions*—(1) *Apportionment.* Apportionment means an allocation or distribution of allowable cost between the beneficiaries of the health insurance program and other patients.

(2) *Routine services.* Routine services means the regular room, dietary, and nursing services, minor medical and surgical supplies, and the use of equipment and facilities for which a separate charge is not customarily made.

(3) *Ancillary services.* Ancillary services or special services are the services for which charges are customarily made in addition to routine services.

(4) *Charges.* Charges refer to the regular rates for various services which are charged to both beneficiaries and other paying patients who receive the services. Implicit in the use of charges as the basis for apportionment is the objective that charges for services be related to the cost of the services.

(5) *Cost.* Cost refers to reasonable cost as described in § 405.451.

(6) *Ratio of beneficiary charges to total charges on a departmental basis.* Ratio of beneficiary charges to total charges on a departmental basis, as applied to inpatients, means the ratio of inpatient charges to beneficiaries of the health insurance program for services of a revenue-producing department or center to the inpatient charges to all inpatients for that center during an accounting period. After each revenue-producing center's ratio is determined, the cost of services rendered to beneficiaries of the health insurance program is computed by applying the individual ratio for the center to the cost of the related center for the period.

(7) *Average cost per diem for routine services.* With respect to cost reporting periods starting before January 1, 1972, average cost per diem for routine services means the amount computed by dividing the total allowable inpatient cost for routine services by the total number of inpatient days of care (excluding newborn days where nursery costs are excluded from routine service costs) rendered by the provider in the accounting period. With respect to cost reporting periods starting after December 31, 1971, average cost per diem for general routine services means the amount computed by

dividing the total allowable inpatient cost for routine services (excluding the cost of services provided in intensive care units, coronary care units, and other special care inpatient hospital units as well as nursery costs) by the total number of inpatient days of care (excluding days of care in intensive care units, coronary care units, and other special care inpatient hospital units and newborn days) rendered by the provider in the accounting period.

(8) *Average cost per diem for hospital special care units.* Average cost per diem for intensive care units, coronary care units, and other special care inpatient hospital units as defined in subparagraph (10) of this paragraph means the amount computed by dividing the total allowable costs for routine services in each (see paragraph (b)(1) of this section), or the aggregate (see paragraph (b)(2) of this section), of these units by the total number of inpatient days of care rendered in each or the aggregate of these units.

(9) *Ratio of beneficiary charges for ancillary services to total charges for ancillary services.* With respect to cost reporting years starting before January 1, 1972, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges for ancillary services to all patients during an accounting period. This ratio is applied to the allowable inpatient ancillary costs for the period to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries. With respect to cost reporting periods starting after December 31, 1971, the ratio of beneficiary charges for ancillary services to total charges for ancillary services, as applied to inpatients, means the ratio of the total inpatient charges for covered ancillary services rendered to beneficiaries of the health insurance program to the total inpatient charges, excluding delivery room charges, for ancillary services to all patients during an accounting period. This ratio is applied to the allowable inpatient ancillary costs for the period, excluding delivery room costs, to determine the amount of reimbursement to a provider for the covered ancillary services rendered to beneficiaries.

(10) *Intensive care units, coronary care units, and other special care inpatient hospital units.* To be considered an intensive care unit, coronary care unit, or other special care inpatient hospital unit, the unit must be in a hospital, must be one in which the care required is extraordinary and on a concentrated and continuous basis and must be physically identifiable as separate from general patient care areas. There shall be specific written policies for each of such designated units which include, but are not limited to burn, coronary care, pulmonary care, trauma, and intensive care units but exclude postoperative recovery rooms, postanesthesia recovery rooms, or maternity labor rooms.

(e) *Application*—(1) *Objective.* (i) The law provides that the costs with respect to individuals covered by the health insurance program will not be borne by individuals not so covered, and, conversely, that costs with respect to individuals who are not under the program will not be borne by the program.

(ii) The cost of services to beneficiaries of the health insurance program may, for cost reporting periods starting before January 1, 1972, be determined by either of the alternative methods that is selected by a provider; however, the objective of whatever method of apportionment is used will be to approximate as closely as practicable the actual cost of services rendered.

(iii) The two methods of apportionment available for use in determining the cost of services rendered to beneficiaries of the program have as their goal the allocation of the total allowable costs between the beneficiaries and other patients in as equitable a manner as possible. Under these methods, if it is found that beneficiaries receive more than the average amount of services, the providers would receive reimbursement greater than average cost for all patients. Conversely, if the beneficiaries receive less than the average amount of services, the providers would be reimbursed accordingly for the services rendered.

(2) *Departmental Method*—(i) *For cost reporting periods starting before January 1, 1972.* The following illustrates how apportionment based on the ratio of beneficiary charges to total charges applied to cost on a departmental basis would be determined for cost reporting periods starting before January 1, 1972, using only inpatient data.

HOSPITAL A

Department	Charges to program beneficiaries	Total charges	Ratio of beneficiary charges to total charges	Total cost	Cost of beneficiary services
			Percent		
Routine services	$140,000	$600,000	23 1/3	$630,000	$147,000
X-ray	24,000	100,000	24	75,000	18,000
Operating room	20,000	70,000	28 4/7	77,000	22,000
Laboratory	40,000	140,000	28 4/7	98,000	28,000
Pharmacy	20,000	60,000	33 1/3	45,000	15,000
Others	6,000	30,000	20	25,000	5,000
Total	250,000	1,000,000		950,000	235,000

To the total shown in the illustration is added, to the extent pertinent, for services provided after June 30, 1969, an inpatient routine nursing salary cost differential adjustment factor as defined and illustrated in § 405.430.

(ii) *For cost reporting periods starting after December 31, 1971.* The following illustrates how apportionment based on the average cost per diem for general routine services, taking into account, to the extent pertinent, an inpatient routine nursing salary cost differential (see § 405.430 for definition and application of this differential) and each special care unit, and apportionment of the cost of ancillary services on the ratio of beneficiary charges to total charges applied to cost by department would be determined for cost reporting periods starting

after December 31, 1971, under the Departmental Method, using only inpatient data:

HOSPITAL Y

Department	Charges to program beneficiaries	Total charges	Ratio of beneficiary charges to total charges	Total cost	Cost of beneficiary services
			Percent		
Operating rooms	$20,000	$70,000	28 4/7	$77,000	$22,000
Delivery rooms	0	12,000	0	30,000	0
Pharmacy	20,000	60,000	33 1/3	45,000	15,000
X-ray	24,000	100,000	24	75,000	18,000
Laboratory	40,000	140,000	28 4/7	98,000	28,000
Others	6,000	30,000	20	25,000	5,000
Total	110,000	412,000		350,000	88,000
	Total inpatient days	Total cost	Average cost per diem	Program inpatient days	Cost of beneficiary services
General routine	30,000	$630,000	$21	8,000	$168,000
Coronary care unit	500	20,000	40	200	8,000
Intensive care unit	3,000	108,000	36	1,000	36,000
	33,500	758,000		9,200	212,000
Total					300,000

To the cost of general routine services rendered to program beneficiaries and to the total shown in the illustration are added, to the extent pertinent, an inpatient routine nursing salary cost differential adjustment factor as defined and illustrated in § 405.430.

(3) *Combination Method*.—(i) *Using cost finding for cost reporting periods starting before January 1, 1972.* A provider may, at its option, for cost reporting periods starting before January 1, 1972, elect to be reimbursed for the cost of routine services on the basis of the average cost per diem, taking into account, to the extent pertinent, for services provided after June 30, 1969, an inpatient routine nursing salary cost differential (as defined and illustrated in § 405.430). To this amount is added the cost of the ancillary services rendered to beneficiaries of the program determined by computing the ratio of total inpatient charges for ancillary services to beneficiaries to the total inpatient ancillary charges to all patients and applying this ratio to the total allowable cost of inpatient ancillary services.

COMBINATION METHOD EMPLOYED BY HOSPITAL B

Statistical and financial data:

Total inpatient days for all patients	30,000
Inpatient days applicable to beneficiaries	7,500
Inpatient routine services—total allowable cost	$600,000
Inpatient ancillary services—total allowable cost	$320,000
Inpatient ancillary services—total charges	$400,000
Inpatient ancillary services—charges for services to beneficiaries	$80,000

Computation of cost applicable to program:

Average cost per diem for routine services: $600,000 ÷ 30,000 days = $20 per diem.	
Cost of routine services (exclusive of any inpatient routine nursing salary cost differential adjustment factor pertinent for services provided after June 30, 1969) rendered to beneficiaries: $20 per diem × 7,500 days	$150,000
Ratio of beneficiary charges to total charges for all ancillary services: $80,000 ÷ $400,000 = 20 percent.	
Cost of ancillary services rendered to beneficiaries: 20 percent × $320,000	$64,000
Total cost (exclusive of any inpatient routine nursing salary cost differential adjustment factor pertinent for services provided after June 30, 1969) of beneficiary services	$214,000

To the cost of routine services and total cost shown in the above illustration are added, to the extent pertinent, for services provided after June 30, 1969, an inpatient routine nursing salary cost differential adjustment factor as defined and illustrated in § 405.430.

(ii) *Using estimated percentage.* For periods ending after December 31, 1968, providers are required to use the cost-finding methods described in § 405.453 to determine the costs of routine and ancillary services. Where the intermedi-

ary determines, however, that a provider is unable to make the necessary computations by cost-finding methods as indicated in § 405.453, the intermediary will estimate the appropriate percentage of the provider's allowable cost that represents routine service costs and the appropriate percentage that represents the ancillary service costs. These percentages are to be based upon study, analysis, and judgment by the intermediary and designed to approximate the result that a cost-finding method would have produced for the particular provider. The use of estimated percentages would apply only to cost reports for periods ending before January 1, 1969. For subsequent periods, the use of cost-finding methods as described in § 405.453 will be required for the apportionment of allowable costs.

ESTIMATED PERCENTAGE EMPLOYED BY HOSPITAL C

Statistical and financial data:	
Total inpatient days for all patients	35,000
Inpatient days applicable to beneficiaries	5,000
Total allowable inpatient cost	$1,000,000
Estimated percent for routine inpatient services	70
Estimated percent for ancillary inpatient services	30
Inpatient ancillary services:	
Total charges	$400,000
Charges for services to beneficiaries	$80,000
Computation of cost applicable to program:	
Average cost per diem for routine services:	
70 percent × $1,000,000=$700,000 (routine service cost).	
$700,000÷35,000 days=$20 per diem.	
Cost of routine services rendered to beneficiaries: $20 per diem × 5,000 days	$100,000
Ratio of beneficiary charges to total charges for all ancillary services: $80,000÷$400,000=20 percent.	
Cost of ancillary services rendered to beneficiaries:	
30 percent × $1,000,000=$300,000 (ancillary service costs).	
20 percent × $300,000	$60,000
Total cost of beneficiary services	$160,000

(iii) *Combination Method for cost reporting periods beginning after December 31, 1971.* The following illustrates how apportionment based on the average cost per diem for general routine services, taking into account, to the extent pertinent, an inpatient routine nursing salary cost differential (see § 405.430 for definition and application of this differential) and the aggregate of the special care units, and apportionment of the cost of ancillary services on the basis of the ratio of total beneficiary ancillary charges to total patient ancillary charges (excluding delivery room charges) applied to the cost of all such ancillary services (excluding delivery room costs) would be determined for cost reporting periods beginning after December 31, 1971, under the Combination Method using only inpatient data.

HOSPITAL Z

Statistical and financial data:	
Total inpatient days for all patients—General area	30,000
Total inpatient days for all patients—All special care units	2,500
Inpatient days applicable to program beneficiaries—General area	7,500
Inpatient days applicable to program beneficiaries—All special care units	750
Total allowable costs—General inpatient routine area	$600,000
Total allowable costs—All special care units	$95,000
Inpatient ancillary services—Total allowable cost excluding delivery room cost	$320,000
Inpatient ancillary services—Total charges excluding delivery room charges	$400,000
Inpatient ancillary services—Charges for services to program beneficiaries	$80,000
Computation of cost applicable to program:	
Average cost per diem for general routine services: $600,000÷30,000=$20 per diem.	
Cost of general routine services (exclusive of any inpatient routine nursing salary cost differential adjustment factor) rendered to program beneficiaries: $20 per diem × 7,500 days	$150,000
Average cost per diem for special care units: $95,000÷2,500=$38 per diem.	
Cost of services rendered to program beneficiaries in special care units: $38 per diem × 750 days	$28,500
Ratio of beneficiary charges to total charges for all ancillary services excluding delivery room charges: $80,000÷$400,000=20 percent.	

Computation of cost applicable to program:—Continued

Cost of ancillary services rendered to program beneficiaries: 20 percent × $320,000	$64,000
Total cost (exclusive of any inpatient routine nursing salary cost differential adjustment factor) of services rendered to program beneficiaries	$242,500

To the cost of general routine services rendered to program beneficiaries and to the total shown in the illustration are added, to the extent pertinent, an inpatient routine nursing salary cost differential adjustment factor as defined and illustrated in § 405.430.

(4) *Option to use Departmental Method or Combination Method for the first reporting period for cost reporting periods beginning before January 1, 1972.* (i) The provider has the option of using either the Departmental Method or the Combination Method for the first reporting period. Thereafter, a provider may change from one to the other method provided a written request is made to the intermediary before the end of the fourth month of the period for which the change is to be applied and such request is approved.

(ii) A request to change from one to the other method made by a provider prior to or at the time it submitted an audited cost report for its first reporting period is acceptable and the change may be made if approved by the intermediary provided that the audited report was submitted before the end of the second reporting period. Providers which submit an audited cost report for the first period after the end of the second reporting period must use the same method of apportionment for both the first and second periods.

(iii) The provisions of subdivisions (i) and (ii) of this subparagraph (4) apply to cost reporting periods beginning before January 1, 1972.

(5) *Temporary methods of apportionment for cost reporting periods ending before January 1, 1969.* (i) The intermediary may find that a provider is unable to apply either the Departmental Method or the Combination Method employing cost finding or estimated percentages. In such case, the intermediary can authorize the provider to use, on a temporary basis, an apportionment based on the ratio of beneficiary inpatient charges to total inpatient charges applied to the total cost of all services. This would permit the provider time to establish the records necessary for applying either of the basic alternative methods of apportionment in the next accounting period. This method may not, however, be used by hospitals which have all-inclusive rates, or no-charge structures. In some cases, the intermediary may determine that a provider is unable to employ this temporary method of apportionment based on the ratio of beneficiary inpatient charges to total inpatient charges applied to total inpatient cost. In such a case any other method determined by the intermediary to be reasonable may be used on a temporary basis, however, methods for providers having all-inclusive rates or no-charge structures will be developed by the Social Security Administration. Any temporary method of apportionment may not be used to cover cost reporting periods ending on or after January 1, 1969.

EXAMPLE: The following illustration demonstrates the apportionment of cost based on the ratio of beneficiary inpatient charges to all inpatient charges computed on a total basis for all inpatient services.

HOSPITAL D

Financial data:	
Inpatient services:	
Total allowable cost	$950,000
Total charges	$1,000,000
Charges for beneficiary services	$200,000
Computation of cost of beneficiary inpatient services:	
Ratio of beneficiary charges to total charges: $200,000 ÷ $1,000,000 = 20 percent.	
Cost of services rendered to beneficiaries: 20 percent × $950,000	$190,000

(ii) Whenever authorization is given to apportion costs by a method other than one of the two basic alternative methods, such authorization would be considered to be a temporary expediency to cover only cost reports for periods ending before January 1, 1969. It would be available to a provider only after diligent efforts have been made by the provider to apportion its costs based upon either of the approved methods of apportionment.

[37 F.R. 10354, May 20, 1972]

§ 405.453 Adequate cost data and cost finding.

(a) *Principle.* Providers receiving payment on the basis of reimbursable cost must provide adequate cost data.

This must be based on their financial and statistical records which must be capable of verification by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data based on such basis of accounting will be acceptable, subject to appropriate treatment of capital expenditures.

(b) *Definitions—(1) Cost finding.* Cost finding is the process of recasting the data derived from the accounts ordinarily kept by a provider to ascertain costs of the various types of services rendered. It is the determination of these costs by the allocation of direct costs and proration of indirect costs.

(2) *Accrual basis of accounting.* Under the accrual basis of accounting, revenue is reported in the period when it is earned, regardless of when it is collected, and expenses are reported in the period in which they are incurred, regardless of when they are paid.

(c) *Adequacy of cost information.* Adequate cost information must be obtained from the provider's records to support payments made for services rendered to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended. Adequate data capable of being audited is consistent with good business concepts and effective and efficient management of any organization, whether it is operated for profit or on a nonprofit basis. It is a reasonable expectation on the part of any agency paying for services on a cost-reimbursement basis. In order to provide the required cost data and not impair comparability, financial and statistical records should be maintained in a manner consistent from one period to another. However, a proper regard for consistency need not preclude a desirable change in accounting procedures when there is reason to effect such change.

(d) *Cost finding methods.* After the close of the accounting period, one of the following methods of cost finding is to be used to determine the actual costs of services rendered during that period. However, for reporting periods beginning after December 31, 1971, providers using the Departmental Method of cost apportionment must use the Step-Down Method described in subparagraph (1) of this paragraph or an "Other Method" described in subparagraph (2) of this paragraph under the conditions provided therein. The modified cost finding method provided in subparagraph (3) of this paragraph must be used for reporting periods beginning after December 31, 1971, by providers which are required to use the Combination Method of cost apportionment.

(1) *Step-down method.* This method recognizes that services rendered by certain nonrevenue-producing departments or centers are utilized by certain other nonrevenue-producing centers as well as by the revenue-producing centers. All costs of nonrevenue-producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the nonrevenue-producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the nonrevenue-producing center, that center will be considered "closed" and no further costs are apportioned to that center. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render service to an equal number of centers while receiving benefits from an equal number, that center which has the greatest amount of expense should be allocated first.

(2) *Other methods—(i) The double-apportionment method.* The double-apportionment method may be used by a provider upon approval of the intermediary. This method also recognizes that the nonrevenue-producing departments or centers render services to other nonrevenue-producing centers as well as to revenue-producing centers. A preliminary allocation of the costs of nonrevenue-producing centers is made. These centers or departments are not "closed" after this preliminary allocation. Instead, they remain "open," accumulating a portion of the costs of all other centers from which services are received. Thus, after the first or preliminary allocation, some costs will remain in each center representing services received from other centers. The first or preliminary allocation is followed by a second or final apportionment of expenses involving the allocation of all costs remaining in the nonrevenue-producing functions directly to revenue-producing centers.

(ii) *More sophisticated methods.* A more sophisticated method designed to allocate costs more accurately may be used by the provider upon approval of the intermediary. However, having elected to use the double-apportionment method, the provider may not thereafter use the step-down method without approval of the intermediary. Written request for the approval must be made on a prospective basis and must be submitted before the end of the fourth month of the prospective reporting period. Likewise, once having elected to use a more sophisticated method, the provider may not thereafter use either the double-apportionment or step-down methods without similar request and approval.

(3) *Modified cost finding for providers using the Combination Method for reporting periods beginning after December 31, 1971.* This method differs from the Step-Down Method in that services rendered by nonrevenue-producing departments or centers are allocated directly to revenue-producing departments or centers even though these services may be utilized by other nonrevenue-producing departments or centers. In the application of this method the cost of nonrevenue-producing centers having a common basis of allocation are combined and the total distributed to revenue producing centers. All nonrevenue-producing centers having significant percentages of cost in relation to total costs will be allocated this way. The combined total costs of remaining nonrevenue-producing cost centers will be allocated to revenue-producing cost centers in the proportion that each bears to total costs, direct and indirect, already allocated. The bases which are to be used and the centers which are to be combined for allocation are not optional, but are identified and incorporated in the cost report forms developed for this method. Providers using this method must use the program cost report forms devised for it. Alternative forms may not be used without prior approval of the Social Security Administration, based upon a written request by the provider submitted through the intermediary.

(4) *Temporary method for initial period.* If the provider is unable to use either cost-finding method when it first participates in the program, it may apply to the intermediary for permission to use some other acceptable method which would accurately identify costs by department or center, and appropriately segregate inpatient and outpatient costs. Such other method may be used for cost reports covering periods ending before January 1, 1968.

(e) *Accounting basis.* The cost data submitted must be based on the accrual basis of accounting which is recognized as the most accurate basis for determining costs. However, governmental institutions that operate on a cash basis of accounting may submit cost data on the cash basis subject to appropriate treatment of capital expenditures.

(f) *Cost reports.* For cost reporting purposes, the health insurance program requires each provider of services to submit periodic reports of its operations which generally cover a consecutive 12-month period of the provider's operations. Amended cost reports to revise cost report information which has been previously submitted by a provider may be permitted or required as determined by the Social Security Administration.

(1) *Cost reports—terminated providers and changes of ownership.* A provider which voluntarily or involuntarily ceases to participate in the health insurance program or experiences a change of ownership must file a cost report for that period under the program beginning with the first day not included in a previous cost reporting period and ending with the effective date of termination of its provider agreement or change of ownership.

(2) *Due dates for cost reports.* (i) Cost reports are due on or before the last day of the third month following the close of the period covered by the report.

(ii) A 30-day extension of the due date of a cost report may, for good cause, be granted by the intermediary, after first obtaining the approval of the Social Security Administration.

(iii) The cost report from a provider which voluntarily or involuntarily ceases to participate in the health insurance program or experiences a change of ownership is due no later than 45 days following the effective date of the termination of the provider agreement or change of ownership.

[31 FR 14818, Nov. 22, 1966, as amended at 33 F.R. 11274, Aug. 8, 1968; 37 F.R. 10357, May 20, 1972; 37 F.R. 21630, Oct. 14, 1972]

§ 405.454 Payments to providers.

(a) *Principle.* Providers of services will be paid the reasonable cost of services furnished to beneficiaries. Interim payments approximating the actual costs of the provider will be made on the most expeditious basis administratively feasible but not less often than monthly. A retroactive adjustment based on actual costs will be made at the end of the reporting period.

(b) *Amount and frequency of payment.* Title XVIII of the act states that providers of services will be paid the reasonable cost of services furnished to beneficiaries. Since actual costs of services cannot be determined until the end of the accounting period, the providers must be paid on an estimated cost basis during the year. While the law provides that interim payments shall be made no less often than monthly, intermediaries are expected to make payments on the most expeditious basis administratively feasible. Whatever estimated cost basis is used for determining interim payments during the year, the intent is that the interim payments shall approximate actual costs as nearly as is practicable so that the retroactive adjustment based on actual costs will be as small as possible.

(c) *Interim payments during initial reporting period.* At the beginning of the program or when a provider first participates in the program, it will be necessary to establish interim rates of payment to providers of services. Once a provider has filed a cost report under the health insurance program, the cost report may be used as a basis for determining the interim rate of reimbursement for the following period. However, since initially there is no previous history of cost under the program, the interim rate of payment must be determined by other methods, including the following:

(1) Where the intermediary is already paying the provider on a cost or cost-related basis, the intermediary will adjust its rate of payment to the program's principles of reimbursement. This rate may be either an amount per inpatient day, or a percent of the provider's charges for services rendered to the program's beneficiaries.

(2) Where an organization other than the intermediary is paying the provider for services on a cost or cost-related basis, the intermediary may obtain from that organization or from the provider itself the rate of payment being used and other cost information as may be needed to adjust that rate of payment to give recognition to the program's principles of reimbursement.

(3) Where no organization is paying the provider on a cost or cost-related basis, the intermediary will obtain the previous year's financial statement from the provider. By analysis of such statement in the light of the principles of reimbursement, the intermediary will compute an appropriate rate of payment.

(4) After the initial interim rate has been set, the provider may at any time request, and be allowed, an appropriate increase in the computed rate, upon presentation of satisfactory evidence to the intermediary that costs have increased. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(d) *Interim payments for new providers.* (1) Newly established providers will not have cost experience on which to base a determination of an interim rate of payment. In such cases, the intermediary will use the following methods to determine an appropriate rate:

(i) Where there is a provider or providers comparable in substantially all relevant factors to the provider for which the rate is needed, the intermediary will base an interim rate of payment on the costs of the comparable provider.

(ii) If there are no substantially comparable providers from whom data are available, the intermediary will determine an interim rate of payment based on the budgeted or projected costs of the provider.

(2) Under either method, the intermediary will review the provider's cost experience after a period of 3 months. If need for an adjustment is indicated, the interim rate of payment will be adjusted in line with the provider's cost experience.

(e) *Interim payments after initial reporting period.* Interim rates of payment for services provided after the initial reporting period will be established on the basis of the cost report filed for the previous year covering health insurance services. The current rate will be determined—whether on a per diem or percentage of charges basis—using the previous year's costs of covered services and making any appropriate adjustments required to bring, as closely as possible, the current year's rate of interim payment into agreement with current year's costs. This interim rate of payment may be adjusted by the intermediary during

an accounting period if the provider submits appropriate evidence that its actual costs are or will be significantly higher than the computed rate. Likewise, the intermediary may adjust the interim rate of payment if it has evidence that actual costs may fall significantly below the computed rate.

(f) *Retroactive adjustment.* (1) Title XVIII of the Act provides that providers of services shall be paid amounts determined to be due, but not less often than monthly, with necessary adjustments due to previously made overpayments or underpayments. Interim payments are made on the basis of estimated costs. Actual costs reimbursable to a provider cannot be determined until the cost reports are filed and costs are verified. Therefore, a retroactive adjustment will be made at the end of the reporting period to bring the interim payments made to the provider during the period into agreement with the reimbursable amount payable to the provider for the services rendered to program beneficiaries during that period.

(2) In order to reimburse the provider as quickly as possible, an initial retroactive adjustment will be made as soon as the cost report is received. For this purpose, the costs will be accepted as reported—unless there are obvious errors or inconsistencies—subject to later audit. When an audit is made and the final liability of the program is determined, a final adjustment will be made.

(3) To determine the retroactive adjustment, the amount of the provider's total allowable cost apportioned to the program for the reporting year is computed. This is the total amount of reimbursement the provider is due to receive from the program and the beneficiaries for covered services rendered during the reporting period. The total of the interim payments made by the program in the reporting year and the deductibles and coinsurance amounts receivable from beneficiaries is computed. The difference between the reimbursement due and the payments made is the amount of the retroactive adjustment.

(g) *Outstanding current financing payments.* Prior to May 29, 1973, current financing payments were authorized to providers of services, at their request, to reimburse them currently as services were furnished to beneficiaries. Such payments were in addition to the basic procedure for payments to providers. Effective May 29, 1973, current financing payments shall not be made. Any current financing payments outstanding on May 29, 1973, constitute overpayments which are due and payable to the Social Security Administration as of such date. If refund is not made the Social Security Administration may recover such overpayments by withholding payments, in whole or in part, otherwise due the provider of services under title XVIII of the Social Security Act, in accordance with procedures established by the Administration, notwithstanding any provision to the contrary in §§ 405.370 to 405.373.

(h) *Accelerated payments to providers.* Upon request, an accelerated payment may be made to a provider of services where the provider has experienced financial difficulties due to a delay by the intermediary in making payments or in exceptional situations, where the provider has experienced a temporary delay in preparing and submitting bills to the intermediary beyond its normal billing cycle. Any such payment must be approved first by the intermediary and then by the Social Security Administration. The amount of the payment is computed as a percentage of the net reimbursement for unbilled and/or unpaid covered services. Recovery of the accelerated payment may be made by recoupment as provider bills are processed and/or by direct payment.

(i)-(j) [Reserved]

(k) *Bankruptcy or insolvency of provider.* If on the basis of reliable evidence, the intermediary has a valid basis for believing that, with respect to a provider, proceedings have been or will shortly be instituted in a State or Federal court for purposes of determining whether such provider is insolvent or bankrupt under an appropriate State or Federal law, any payments to the provider shall be adjusted by the intermediary, notwithstanding any other regulation or program instruction regarding the timing or manner of such adjustments, to a level necessary to insure that no overpayment to the provider is made.

[31 F.R. 14819, Nov. 22, 1966, as amended at 32 FR 5260, Mar. 29, 1967; 37 FR 21630, Oct. 4, 1972; 38 FR 14093, May 29, 1973]

The 2% allowance in lieu of specific recognition of other costs was provided for at 20 CFR 405.428 (31 Fed. Reg. 7871 (1966)):

§ 405.428 Allowance in lieu of specific recognition of other costs.

(a) *Principle.* In lieu of specific recognition of other costs in providing and improving services, an allowance amounting to 2 percent of costs allowed under the other principles (with the exception of interest expense) is includable as an element of reasonable cost of services, subject to the limitation that the allowance not exceed a reasonable long-term interest rate on the provider's net investment related to patient care.

(b) *Application.* Difficulty in measurement, lack of adequate data and other considerations have precluded specific recognition of various elements which are germane to costs of services for beneficiaries. Moreover, although the methods to be utilized by providers for determining the actual cost of services provided to beneficiaries are the best available, there is some lack of precision in methods at the present stage of development of cost finding which represents a contingency for which recognition is appropriate. It is the established practice of a significant number of large third-party purchasers to include in payment for costs of services a factor in the form of an allowance to cover various elements not specifically recognized or not precisely measured. This allowance is, in part, in lieu of a specific interest return on equity capital as well as other factors not given specific recognition. The allowance under this principle is limited to an amount which, as a percentage of the provider's investment in plant, property, and equipment related to patient care (net of depreciation and long-term debt related to such investment), does not exceed the average interest rate on special issues of public-debt obligations issued to the Federal Hospital Insurance Trust Fund during the reporting period (i.e., the appropriate average of the several monthly rates, as determined under section 1817(c) of the Social Security Act). In the determination of the amount of the provider's net investment, for purposes of applying this limitation, the cost of assets financed by Hill-Burton or other Federal funds will be excluded. Such exclusion will be on the basis of the share of the cost financed by Federal funds after adjustment for depreciation.

The current financing system was provided for at 20 CFR 405.454(g) (31 Fed. Reg. 7875 (1966)):

(g) *Provision for current financing.* (1) In addition to the basic procedure for payment to a provider following the submission of bills to the intermediary, payment will be made upon request by the provider on a basis designed to reimburse concurrently as services are furnished to beneficiaries. The amount of such payment will be computed by the intermediary initially on an estimated basis and periodically adjusted to represent the average level of services unreimbursed by the basic payment procedure.

(2) A study will be made of the possibility that a financial requirement in the production of services arises prior to the rendition of services to beneficiaries and is not being met by the program. Among the factors to be considered in the study will be the extent to which outlays for consumable items for which payment may be made in advance of rendition of services are offset by outlays for other items, such as wages and salaries, which ordinarily are not made until after services are rendered.

The New PIP regulation is provided for at

20 CFR 405.454(j) (40 Fed. Reg. 29815-17 (1975)):

§ 405.454 Payments to providers.

* * * * *

(j) *Periodic interim payment method of reimbursement.* In addition to the regular methods of interim payment on the detailed provider billings for covered services, the periodic interim payment (PIP) method is available for Part A hospital and skilled nursing facility inpatient services and for both Part A and Part B home health agency services.

(1) Any participating provider that establishes to the satisfaction of the intermediary that it meets the following requirements may elect to be reimbursed under the PIP method beginning with the first month after its request that the intermediary finds administratively feasible:

(i) The provider's estimated total Medicare reimbursement for inpatient services is at least $25,000 a year computed under the PIP formula or, in the case of a home health agency, either (A) its estimated total Medicare reimbursement for Part A and Part B services is at least $25,000 a year computed under the PIP formula or (B) its estimated Medicare reimbursement computed under the PIP formula is at least 50 percent of estimated total allowable costs,

(ii) The provider has filed at least one completed Medicare cost report accepted by the intermediary as providing an accurate basis for computation of program payment (except in the case of a provider requesting reimbursement under the PIP method upon first entering the program),

(iii) The provider has the continuing capability of maintaining in its records the cost, charge, and statistical data needed to accurately complete a Medicare cost report on a timely basis, and

(iv) The provider has repaid or agrees to repay any outstanding current financing payment in full, such payment to be made before the effective date of its requested conversion from a regular interim payment method to the PIP method.

(2) No conversion to the PIP method may be made with respect to any provider until after that provider has repaid in full its outstanding current financing payment.

(3) The intermediary's approval of a provider's request for reimbursement under the PIP method will be conditioned upon the intermediary's best judgment as to whether payment can be made to the provider under the PIP method without undue risk of its resulting in an overpayment because of greatly varying or substantially declining Medicare utilization, inadequate billing practices, or other circumstances. The intermediary may terminate PIP reimbursement to a provider at any time it determines that the provider no longer meets the qualifying requirements or that the provider's experience under the PIP method shows that proper payment cannot be made under this method.

(4) Payment will be made biweekly under the PIP method unless the provider requests a longer fixed interval (not to exceed 1 month) between payments. The payment amount will be computed by the intermediary to approximate, on the average, the cost of covered inpatient or home health services rendered by the provider during the period for which the payment is to be made, and each payment will be made 2 weeks after the end of such period of services. Upon request, the intermediary will, if feasible, compute the provider's payments to recognize significant seasonal variation in Medicare utilization of services on a quarterly basis starting with the beginning of the provider's reporting year.

(5) A provider's periodic interim payment amount may be appropriately adjusted at any time if the provider presents or the intermediary otherwise obtains evidence relating to the provider's costs or Medicare utilization that warrants such adjustment. In addition, the intermediary will recompute the payment immediately upon completion of the desk review of a provider's cost report and also at regular intervals not less often than quarterly. The intermediary may make a retroactive lump sum interim payment to a provider, based upon an increase in its periodic interim payment amount, in order to bring past interim payments for the provider's current cost reporting period into line with the adjusted payment amount. The objective of intermediary monitoring of provider costs and utilization is to assure payments approximating, as closely as possible, the reimbursement to be determined at settlement for the cost reporting period. A significant factor in evaluating the amount of the payment in terms of the realization of the projected Medicare utilization of services is the timely submittal to the intermediary of completed admission and billing forms. All providers must complete billings in detail under this method as under regular interim payment procedures.

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